

**THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH  
WITHIN THE SOUTH AFRICAN CONTEXT: NAMING THE UNNAMED  
CONFLICT**

by

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Exact wording of the title of the thesis or thesis as appearing on the copies submitted for examination:

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I further declare that I submitted the thesis to originality checking software. The result summary is attached in the Appendices. I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

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DATE

## **TITLE OF THESIS:**

### **THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH WITHIN THE SOUTH AFRICAN CONTEXT: NAMING THE UNNAMED CONFLICT**

## **SUMMARY:**

The interface of religion, spirituality and mental health was investigated by conducting interviews with a group of Protestant evangelical pastors, and a group of registered counselling/clinical psychologists. The participants were selected through snowball sampling and were asked to describe their perceptions of, and experiences with religion, spirituality, and mental health in their respective positions as pastors and psychologists. The interview protocols were analysed through thematic analysis where themes were drawn from the data provided by participants. The data showed that both the pastors and the psychologists perceived a distance between the disciplines of religion, spirituality and mental health. The pastors described this distance as representing “two worlds”, a world of religion and spirituality and, a separate world of mental health. The psychologists similarly described an “unnamed conflict” that arises between the two worlds that can, at times, be characterised by perceived tension, discomfort and uncertainty. This tension has been amplified by the cultural climate of secularism in which religion had been marginalised and relegated to the private, rather than the public sphere of societal functions. With the shift to post-secularism has come greater acknowledgement of the role of religion and spirituality for individuals in society, bringing the necessity to consider the interface of religion, spirituality and mental health within mainstream psychological science. The data showed, however, that neither the psychologists nor the pastors had received formal training in this interface, which had resulted in high levels of ignorance and stigmatisation both between, and within the disciplines. Some of the stigmatisation about the interface of religion, spirituality and psychology could be attributed to the socio-political history of South Africa, making such stigmatisations indigenous to this country. Not only is training required on this interface, but as part of the findings of this study, an official position statement is proposed regarding Psychology’s approach to the interface of religion, spirituality and mental health, so that the proposed position statement can guide ethical psychological practice within the South African context. Despite the perception of the “two worlds” and the “unnamed conflict”, both the pastors and the psychologists agreed that collaboration between the two disciplines would be optimal, were committed to such a collaborative process, and provided suggestions about how that collaboration could be fostered. By naming the dynamics that characterise the “unnamed conflict”, greater levels of knowledge, transparency, respect, communication, openness, understanding, and ethical astuteness would serve to diminish the distance between the “two worlds”.

## **KEY TERMS:**

Religion, spirituality, psychology, mental health, South African context, health care, biopsychosocial-spiritual model, secularism, post-secularism, culture, perceptions, pastors, psychologists, thematic analysis, interdisciplinary, intradisciplinary, ethics.

## **Acknowledgements**

### **Dedication of PhD Thesis:**

This study is dedicated to my first born son, Samuel-James Greyvensteyn, who passed away after a short illness. The privilege of having known Sammy-J, loving him, and losing him was the catalyst for this PhD. Having personally wrestled between my faith and my psychological training while I grieved for him gave me a poignant experience that lay the groundwork for this study. I honour Samuel-James' life for how it irrevocably changed mine, and how it will continue to influence the lives of many.

### **Acknowledgements:**

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## **Thank you:**

I thank the Lord for every thought, every idea, every solution, every question, every opportunity, and every inspiration that He gave me in knitting this study together. I praise God wholeheartedly and attribute this achievement to his grace and provision in my life. His goodness is never-changing and his faithfulness overwhelms me.

Without my incredible husband, Jan, this endeavour would truly not have been possible. He was my cheerleader throughout this process, on the good days and the bad. He was my sounding board for each glitch and for each small victory, even referring to the study as “our PhD” to show his dedication to the process. He took on parental responsibilities and served me continuously in order to free me to complete this study. He loved me through every moment and never missed an opportunity to spur me on. Not only is he a much loved husband, but he is also a treasured best friend, and a gift from the Lord.

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## INTRODUCTION AND THESIS OUTLINE

The structure of this thesis includes a literature review chapter, a methodology chapter, a theoretical point of departure chapter, two findings chapters, and a conclusion/discussion chapter. Throughout the thesis, the terms religion and spirituality will be referred to as R/S where fitting.

The literature review has been included as the first chapter so that the reader can be provided with information about the interface of religion, spirituality, and mental health in both the South African and international realms. With this thesis being one that considers two disciplines, and the interface thereof, the literature review provides insight into how this interface occurs within various contexts and sets the basis upon which to understand the findings and conclusion chapters. The literature review further sets the context for the introduction of the problem statement in Section Six of Chapter One.

The aims, objectives and research questions were included in the methodology chapter, Chapter Two, due to thematic analysis necessitating research in a consistently self-reflexive manner. In order to situate the reader within the ontological and epistemological position of the researcher, the aims, objectives and research questions have been discussed within the framework of the thematic analysis, and hence have been considered in the methodology chapter to ensure transparency and self-reflexivity.

The findings have been divided into two chapters so that the data can be discussed in a clear manner for the two disciplines represented, i.e. relating to the pastors and the psychologists who had formed the two research participant groups. The interface of the data collected respectively from the pastors and from the psychologists is then reviewed in the conclusion and discussion chapter. By discussing the findings in this format, the findings that are specific to each data set can be easily assessed, as can the analysis on the interface of the two disciplines.

Please also note that the use of the terms black, white, coloured and Indian are culturally acceptable terms in the South African context and are used to indicate classification of race. These terms do not carry emotional connotations, they are neutral terms and are not seen to be derogatory, as may be the case in other parts of the world. The coloured racial group is traditionally known as mixed race, but is referred to as coloured in South Africa. For the sake of consistency, these classifications (apart from Indian) will not be capitalised throughout this thesis, unless used within the title of a publication to be summarised.

This thesis has been written according to South African grammatical rules, and has been formatted according to the American Psychological Association Referencing Style, 6<sup>th</sup> Edition.

**CHAPTER ONE**

**LITERATURE SURVEY**

**Section One: Introduction and Chapter Discussion**

**Section Two: Definitions of Religion and Spirituality**

**Section Three: Brief Review of the Integration of Psychology and Religion/Spirituality Models of Integration**

Models of Integration

The Argument of Biblical Sufficiency

**Section Four: The International Landscape of Religion, Spirituality and Mental Health**

Past Studies: Values Debate

Past Studies: Psychology and Religion

Current Studies and Research

Guidelines for the Integration of Religion and Spirituality in Healthcare

Sample of Studies

**Section Five: The South African Landscape of Religion, Spirituality and Mental Health**

South African Based Studies on Religion, Spirituality and Mental Health

South African Legislation and Ethical Parameters for Practice

South African Based Research

**Section Six: Implications and Conclusions Specific to the South African Context**

## **Section One: Introduction and Chapter Layout**

The subject of religion, spirituality and mental health is a vast one with innumerable possibilities for discussion. For the purposes of this study, however, the literature survey has been structured with relevance to the research question. The aim of this chapter is to build a holistic but succinct picture of the national and international academic landscape of religion, spirituality and mental health, particularly as it pertains to Psychology. The factors most applicable to the research questions, as well as the findings and discussions chapters, have been included in this chapter for ease of cross-referral throughout the thesis. This literature chapter is by no means one that comprehensively discusses these subject matters, because the scope of this study is limited. The definitions of religion and spirituality as relevant to the field of Psychology will be reviewed and will be followed by a discussion about the relationship between these disciplines. The international and South African trends in the integration of religion and spirituality with healthcare will be considered, and will be followed by an evaluation of the implications thereof.

## **Section Two: Definitions of Religion and Spirituality**

In reviewing literature about religion and spirituality, it has become clear that the definition of, and distinction between religion and spirituality is not one that is consistently or clearly defined (De Jager Meezenbroek, Garssen, Van den Berg, Van Dierendonck, Visser, and Schaufeli, 2012). As Kourie (2006, p. 22) states, there is “no clear, unequivocal definition of the concept that is acceptable to all interested in the field”. Kourie (2006) goes on to explain that there is much confusion about the meaning of spirituality, and so the use of the term has become rather “fluid” (Kourie, 2006, p. 22). Although the terms religion and spirituality have been defined by countless authors and sources, for the purposes of this study, the definitions that supply the most consistent and clear explanations will be discussed.

### **Defining Spirituality**

According to Casey (2009), in previous centuries the terms spirituality and religion were closely linked, with spirituality being considered as a part of religion. Spirituality was seen to include more traditional religiously informed practices such as the attendance of church and prayer, but also included contemplative spiritual practices such as meditation and studying

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of sacred texts. In recent times, there has been a shift in the inherent association of spirituality with religion, to spirituality being more broadly defined outside of religion. Spirituality is separated from religion in the sense that one does not have to be religious in order to be spiritual. Some purist followers of spirituality have an antagonistic perspective of religion and see the two as being “mutually exclusive” (Kourie, 2006, p. 24). This is not the only relationship that exists between religion and spirituality, however, as some people believe it is spirituality that gives life to their religious beliefs and traditions (Kourie, 2006).

The split between how religion and spirituality is defined can be partly explained through the socio-cultural movement known as secularism. As Habermas, Blair and Debray (2008) posit, the secularisation of society has led to religious institutions losing their authority and influence on regulatory societal systems such as law, education and politics. The primary function of religious institutions has shifted back to a focus on securing peoples’ salvation. This is a function most commonly practiced in a private realm, which means that society in the public realm experiences religion and religious institutions as being less relevant for their lives. As the movement of secularism grew, the realisation that societal members could embrace spirituality independently of religion began to increase dramatically (Casey, 2009). Spirituality was increasingly differentiated from religion and became associated with the sacred rather than with a specific deity (Casey, 2009). Loewenthal (2013) states that there has been a polarisation between church and state which has greatly impacted how religion functions socially and psychologically within society. It is not therefore surprising then that spirituality has gained momentum and popularity over religion (Cobb, 2014).

In this way, spirituality refers to a higher power, or a supernatural force, but that force is no longer confined to God or being associated with a specific religious institution. Although spirituality can be differentiated into religious well-being and existential well-being, the common spiritual factor remains the search for an experience with the sacred (Khumalo, Wissing, & Schutte, 2014). South African authors Kourie and Ruthenberg (2009) describe the fundamental definition of spirituality as being an expression of the lived, everyday life of ordinary people and the experiences that they have. Spirituality in its broadest reference is understood as being multi-religious, multi-cultural and multi-disciplinary, but spirituality can also be defined according to a specific faith tradition, for example Christian spirituality, which is the spirituality practised within contemporary Christian life (Kourie & Ruthenberg, 2009).

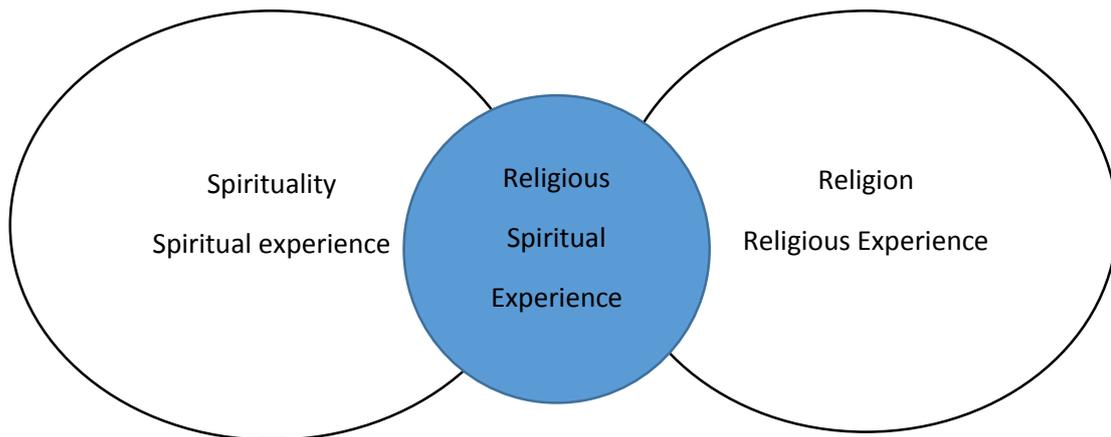
## THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH

Hill et al. (1999) extrapolate the various forms that spirituality can take by classifying spirituality into three domains. God-oriented spirituality is embedded within theology, world-oriented spirituality considers one's relationship to the natural world and to nature, and humanistic spirituality emphasises human achievement and potential. Casey (2009, p. 2) similarly uses four categories of classification for spirituality and religion to demonstrate their separateness and distinction:

1. Spiritual and religious: a more traditional view in which spirituality and religion are interconnected;
2. Spiritual but not religious: the newest group to be distinguished in the light of secularism and other societal changes;
3. Neither religious nor spiritual: for example, atheists or agnostics; and
4. Religious but not spiritual: possess an extrinsic form of religion.

These taxonomies (Hill et al., 1999 & Casey, 2009) are illustrative of how spirituality can either be associated with, or dissociated from religion. As Pretorius (2008) mentions, a spiritual experience can encompass a religious experience for some people, but is separated for others. This is because the term "experience" is defined not according to religious or spiritual categories, but is defined as "a form of knowledge, accompanied by emotions and feelings, that is obtained as a result of the direct reception of an impression of a reality (internal or external), which lies outside our control, and that has an impact on our reaction or consciousness and being" (Pretorius, 2008, p. 148). From this definition, it can be concluded that a person can have a distinctly spiritual experience, a distinctly religious experience, or can have a simultaneous experience of both.

Pretorius illustrates the above definition with the following diagram (Pretorius, 2008, p. 152) to depict the realm of spirituality and spiritual experience, the realm of religious and spiritual experience, as well as the realm in which religion and religious experience are found:



*Figure 1: The realm of spiritual and religious experience, Pretorius (2008, p. 152)*

When considering spirituality and spiritual experience as distinct from religion or religious experience, it is necessary to understand the root word from which spirituality is formed. The Latin root word that spirituality is derived from is *spiritus* which means the “breath of life” (Miller, 2003) while the Latin term *spiritulis* refers to a person of the spirit (Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000). Therefore, spirituality is a multidimensional construct which can be associated with a multitude of dimensions, some can be listed as follows:

- “Spirituality refers to the experiences of consciously striving to integrate one’s life, in terms not of isolation and self-absorption, but of self-transcendence towards the ultimate value one perceives” (Schneiders, 1986, p. 692, as cited in Kourie & Ruthenberg, 2009, p. 77);
- Schneiders (2003) defines spirituality as an anthropological characteristic of human beings involving their capacity to transcend beyond themselves to form relationships with others; in this way spirituality is developed relationally to a transcendent being, to others, to the world in general, and to oneself, which involves experience and a lived personal reality;
- South African authors, Mahlangulu and Uys (2004, p.15) define spirituality as: “A unique individual quest for establishing and maintaining a dynamic transcendent relationship with oneself, others (Ubuntu) and with God/supernatural being as understood by the person. Faith, trust and religious beliefs were reported as antecedents of spirituality, while hope, inner peace and meaningful life were reported to be consequences of spirituality.”;

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- Spirituality may be described as an ultimate reality and the human experience of this reality (Moreira-Almeida, Sharma, Janse van Rensburg, Verhagen, & Cook, 2015);
- De Jager Meezenbroek et al. (2012) have condensed many definitions of spirituality into a primary one of spirituality being “one’s striving for and experience of connection with oneself, connectedness with others and nature, and connectedness with the transcendent” (De Jager Meezenbroek et al., 2012, p. 3);
- Connectedness is a central tenet in understanding spirituality, because it refers to the subjective experience of the sacred, where connectedness is central (Naidu & Ramlall, 2016);
- Not only does spirituality relate to connectedness, but it also encompasses a sense of well-being and contentment (Casey, 2009);
- Spirituality is the search for meaning and purpose in one’s life and it is influenced by the experiences one has in everyday life (Tokpah & Middleton, 2013);
- Spirituality is not confined to the experience of an individual, but can also develop within the context of a community, a tradition, or a culture (Van Rensburg, 2014; Moreira-Almeida et al., 2015);
- Zinnbauer, Pargament, and Scott (1999, p. 909) define spirituality as “the paths people take in their efforts to find, conserve, and transform the sacred in their lives”;
- Janse van Rensburg (2014, p. 134) considers the necessity to delineate spirituality in a manner that is conducive to the South African context, which he achieves in this definition: “progressive, individual or collective inner capacity, consciousness or awareness. It also comprises relational aspects, or connectedness, and essentially exists as a process, representing growth, or a journey. This capacity, consciousness and connectedness provide the motivating drive for living and constitute the source from which meaning and purpose is derived”. Janse van Rensburg (2014) further stipulates that this definition of spirituality includes monotheistic and pantheistic traditions, non-religious or atheistic, agnostic and secular forms of religion and spirituality;
- “Spirituality is the dynamic dimension of human life that relates to the way persons (individuals and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to themselves, to others, to nature, to the significant, and/or the sacred” (Puchalski, Vitillo, Hull & Reller, 2014, p. 643).

From the above definitions and descriptions of spirituality, it can be posited that spirituality is a multifaceted construct that refers to a person's connectedness to the sacred, to self, to others, or to nature. This connectedness is expressed in various transcendent ways that provide one with meaning and purpose on an ever-evolving journey of growth.

### **Defining Religion and Religiosity**

In order to define religion effectively, the perceived differences in the constructs of religion and spirituality should be considered. Defining religion has a longer history than the defining of spirituality (Casey, 2009), but is not always referred to positively in academic writing, and is often seen as polarised from, and a hindrance to spirituality (Zinnbauer et al., 1999).

Delle Fave, Brdar, Freire, Vella-Broderick and Wissing (2013, p. 12) define the distinction between religion and spirituality as follows: "spirituality is currently perceived as a dynamic, which is functional to the search for existential meanings, rooted in the subjective experience of transcendence, and thus authenticated and personalised, while religion is described as an institutionalised system of prescriptions and dogmas that constrain the individual into a well-defined pathway". As can be seen from a definition such as this one, it appears as if religion is a less favoured and less popular construct than spirituality (Naidu & Ramlall, 2016) which is open to further debate or discussion. Cobb et al. (2014) see this disparity in definition and popularity as being indicative of the fact that religion and spirituality seem to have become oppositional, the latter being seen as beneficial and the former as restrictive. However, as Pretorius (2008) postulated in Figure 1, there remains a space where religious and spiritual experience can exist in unison. Schneiders (2003, p. 169) refers to this as religion which "denotes a spiritual tradition such as Christianity or Buddhism". When defining religion as an entity in and of itself, there are still several ways in which this definition is expressed, the most applicable of which include:

- Religion is seen by Schneiders (2003, p. 168) as being a "fundamental life stance of the person who believes in transcendent reality, however designated, and assumes some realistic posture before that ultimate reality". Schneiders (2003) goes on to explain that religion involves a person recognising that they have complete dependence on this transcendent being, which causes the person to express reverence for, and reliance on this being while ensuring that they live in a way that honours this being;

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- “Religion usually refers to socially based beliefs and traditions that are often associated with ritual and ceremony” (Janse van Rensburg, 2014, p. 134);
- Religion is an institutionalised system of beliefs and traditions that are related to a divine being (Moreira-Almeida et al. 2015);
- Religion is a pathway to transcendence and includes practices, rituals and symbols which foster nearness to the sacred (Naidu & Ramlall, 2016);
- As a belief system, religion emphasises the requirement of adherents of this religious belief system to comprehensively understand the doctrines thereof (Mokhoathi, 2017);
- Mokhoathi (2017) states that religion can act as a belief system, or as an identity when there is a close link between religion and ethnicity; or as a delineated way of life;
- Religion is an organised system of beliefs that are situated within sacred texts, and from which some people form meaning in their lives (Tokpah, 2013);
- The connotations associated with religion are ones of institution, ritual, and the articulation of doctrines (Kourie, 2006);
- “A search for significance in ways related to the sacred” (Pargament, 2012, p. 169);
- Religion is a formal system of beliefs and perspectives about the world that is shared by a group of people and is communicated in various forms, which determines how these people form an understanding of their lived reality (Cobb et al. 2014);
- Religion is, at times, irrevocably embedded within the particular culture of a society as a whole. Schneiders (2003, p. 169) phrases this phenomenon as such: “what seems to mark religions in the concrete is that they are cultural systems for dealing with ultimate reality, whether or not that ultimate reality is conceptualised as God, and they are organised in particular patterns of creed, code, and cult”;
- “Religion refers to beliefs, practices, relationships, or experiences having to do with the sacred that are explicitly and historically rooted in established institutionalized systems” (Loewenthal, 2013, p. 239).

From the definitions provided above, religion is understood as being an organised system of beliefs that are shared by a group of people who follow similar practices when expressing these beliefs. These beliefs and experiences are directed at establishing connection with the sacred and provide a framework within which people make sense of their existential realities. Della Fave et al. (2013) make reference to religion being a constrained practice that is characterised by dogma; however, this definition was not one that dominated the reviewed literature, and therefore, their definition will not be included as part of the understanding of

religion for this study. Nonetheless, it is noteworthy to recognise the various ways that both religion and spirituality are defined by various sources, and to be cognisant of the fact that some of these definitions favour spirituality over religion. This will be reviewed in greater detail in Section Three. There are ways in which spirituality and religion overlap, and this most often has to do with a search for the sacred and a search for meaning, which is inherent in the definitions of both religion and spirituality.

### **Section Three: Brief Review of the Relationship Between Religion, Spirituality and Mental Health**

It is not possible to provide a comprehensive historical review of the relationship between religion, spirituality and mental health. That specific topic is one that is wide enough to constitute many theses. For the purposes of this study, a review that is directly applicable to the topic of study, the research question, the problem statement, and to subsequent chapters will be discussed so that the most salient aspects of the historical relationship can be captured.

Hill et al. (2000) provide a review of the relationship between faith and science by tracing the development of Psychology back to the 20<sup>th</sup> century works of William James, Stanley Hall, and Edwin Starbuck. Stanley Hall was the first president of the APA and had a personal interest in the study of religious psychology, and William James published “The Varieties of Religious Experience” where he considered the integration of psychology and religion (Kahle & Robbins, 2004). James refers to the position that religion should have in the field of Psychology with the following statement (James, 1902, p.4):

To the psychologist the religious propensities of man must be at least as interesting as any other of the facts pertaining to his mental constitution

From this quote, one can ascertain the psychological importance that James placed on the religious realm of humankind, and its influence on one’s functioning. Not only James made reference to religion in the psychological understanding of people, but Jung, Erikson, and Rogers similarly considered the role of religion within psychology (Kahle & Robbins, 2004), as did Freud, Allport, Fromm and Maslow (Hill et al., 2000). However, when considering the perspectives of the role that religion has in psychological wellbeing, there is a vast range of opinions offered by theorists throughout the history of psychological science (Pargament

2002). Wulff (1996) states that there is no phenomenon that challenges psychologists as much as religion does, which has led to schisms in how psychologists perceive religion. Regardless of these schisms, however, Wulff (1996) maintains that the only way that a psychologist can effectively understand the human condition is by acknowledging the role that religion has for individuals. This consideration should be independent of the psychologist's personal religious and spiritual beliefs, and the significance that religion holds for their own life. The "precarious status of the psychology of religion" (Wulff, 1996, p.44) can be seen in psychologists antipathy towards the study of religion, as well as theologians' concern that psychologists reduce spiritual processes to psychological ones, thereby fundamentally undermining the significance and integrity of their faith, beliefs or practices. Pargament (2002) acknowledges the schisms of opinion towards religion in Psychology and traces the historical responses of criticism towards religion as including perceptions of religion being punitive, illusory, pathological, destructive to mental health, and logically irrational. However, Pargament (2002) recognises that there have been psychological theorists who have described religion in more favourable terms and have seen its role in Psychology as being a pathway to accessing human potential, a source of wholeness, harmony, maturity, wisdom, and a means of promoting wellness, healing, growth and reconciliation in relationships. With this division in perceptions on the role of religion in Psychology, the obvious question of whether religion is helpful arises (Wulff, 1996).

The best explanation of this quandary is one that Pargament, Mahoney, Exline, Jones, and Shafranske (2013) refer to as the discussion around valence. When asking whether or not religion and/or spirituality are psychologically "good" or "bad", the very nature of that question poses a semantic challenge, because it immediately polarises the argument into an either/or discussion. Rather, Pargament et al. (2013) recommend an analysis of the valence that religion and spirituality pose for psychological well-being by reviewing when, how, and why they may fulfil helpful or unhelpful functions in a person's life. Due to the multidimensional forms that religion and spirituality take, one must have an understanding of the social contexts and settings in which this may be expressed, and of the nature of that expression. Only then can a determination of the valence of religion or spirituality be considered, because it will then be considered with contextual relevance.

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The relationship between religion, spirituality and psychology, therefore, is not a simplistic one. As Worthington (2010, p. 86) states in specific reference to psychology and Christianity:

The relationship between psychological science and Christian theology is like a marriage – with periodic conflicts but also a lot of shared intimacy

If one imagines the integration of religion, spirituality and psychology as being one where a relationship is possible, then the nature of that relationship quickly becomes the point of focus. Although Worthington (2010) parallels the relationship to a marriage, this is not the only view on how the relationship should function (McMinn & Campbell, 2007).

Different approaches to the integration of psychology and religion have been suggested by theorists, primarily within the tradition of the Christian religion. Johnson (2010) considers five primary ways in which the relationship of integration can take place within Christianity:

1. The Biblical Counselling View:

This view was originally purported by Jay Adams, otherwise known as nouthetic counselling. This view completely rejects Psychology and Psychiatry as being redundant and secular, and therefore rather draws knowledge and direction from biblical texts and from repentance of sin.

2. Levels-of-Explanation View:

The disciplines of Theology and science (referring to both natural and social science unless otherwise specified) are seen as being completely separate and distinct from one another, each of them offering knowledge that is obtained through discipline-specific modes of inquiry. The knowledge from one discipline cannot be blended with knowledge from another discipline, because each perspective provides its own type of valuable information. The disciplines, therefore, answer different questions from their own perspective of reality, independently from the perspectives of other disciplines.

3. The Integration View:

This view is more accepting of modern Psychology, but places importance on the tenets of Christian faith which can contribute much knowledge to the field of Psychology and mental health. The adherents of this view encourage an interdisciplinary collaboration between Theology and Science, since both

disciplines deal with the human condition. Psychological science, however, is interpreted through a Christian worldview with its relevance being measured against Scriptural truth.

4. The Christian Psychology View:

Within this view, Christian academics, philosophers and mental health professionals generate theory, research and psychological practices according to a Christian worldview. These Christian psychology theories often differ from secular Psychology theories, because of the emphasis on a more theological foundation rather than a psychological one.

5. The Transformational Psychology View:

In this approach there is a departing from the traditional integrationist focus on the understanding of people to one that places equal importance on considering the ethical, relational and experiential manner in which people live out their Christianity. Benner (1998 as cited in Johnson, 2010) developed a model of soul care for the treatment of Christian clients where the focus of care is based on concerns that are more specific to Christians and their existential realities.

Although there are most likely theorists whose theories of integration do not fit into one of these classifications, they have been provided to give context to the divergent ways that religion and spirituality (specifically related to Christianity in this case) are placed in relationship to Psychology and mental health. It can be assumed from the above delineation of classifications that there is potential for tension to arise within these models of integration, particularly with the nouthetic/biblical counselling approach.

The pastors in this PhD study voiced a sense of tension with their experiences of nouthetic/biblical counselling, and mentioned that tension at various points in the interview. Therefore, to provide the context of this tension, a brief review of some of the published academic dialogues that take place between nouthetic counsellors and mental health professionals will be provided briefly in this next section.

### **The Argument of Biblical Sufficiency**

The rejection of Psychology and Psychiatry has been perpetuated by some evangelicals on the basis of biblical sufficiency (De Oliveira & Braun, 2009). Furthermore, Psychology and Psychiatry have also been understood by some authors as being “pseudoscience”, and therefore some Christian counsellors would have no need for the research and techniques that are produced by secular psychologists (De Oliveira & Braun, 2009).

When it comes to the argument of biblical sufficiency, and the validity of the “truth” that Psychology generates, an interesting debate was published between Porter (2010); McMinn and Graham (2010); Sandage and Brown (2010); and Entwistle and Preston (2010). Porter (2010) makes the point that Theology should be seen as the queen of sciences, and Psychology the handmaid of the queen. This is because Porter (2010) questions the epistemic authority of the two disciplines, Theology and Psychology, and concludes that Theology carries epistemic authority that is superior to Psychology. Porter (2010) states that the implication of Psychology having an equally authoritative voice in the determination of “truth” to Theology causes anxiety for theologians, because Psychology could therefore, “run roughshod over Theology” (Porter, 2010, p. 3). If Theology is not given epistemic authority in discussions to which Theology wants to contribute, then theologians become nervous that psychological “truth” will inevitably distort biblical truth. Therefore, theologians prefer to regulate the extent to which Psychology is integrated into Theology to ensure that Theology remains intact. Naturally, this theological standpoint leads to anxiety with psychologists, because they too believe that psychological truth should not be controlled and regulated in order to appease theologians. When professionals from both disciplines become anxious, it creates a defensiveness which leads to a polarisation of the two disciplines, rather than a workable integration.

To counter this polarisation, Porter (2010) makes the argument that Theology is of a higher authority than Psychology and therefore, the most effective form of integration is one where a hierarchical arrangement is accepted by the disciplines so that the roles of each discipline are clearly understood. The fact that Theology is afforded a greater authority than Psychology is because Porter (2010) sees the theological claims that he is referring to as being derived directly from biblical Scripture, which is argued as being infallible, and subsequently more “true” than psychological claims. The superior authority of Theology is secondly argued from the perspective that Theology is based on information that is linguistic in origin versus

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Psychology which is drawn from observables, e.g. human functioning. Misinterpretation is deemed more likely when claims are drawn from observation (Psychology) than when based on a linguistic form of communication (Theology).

Porter (2010) goes on to explain that the claims made by theologians about natural reality contain more inherent truth than psychological claims, because theological claims reflect Scripture, which is God's truth, and is seen as infallible. In contrast, psychological claims are understood by Porter (2010) as reflecting natural reality that is based on a psychological community's understanding of that reality, which is far more fallible. Therefore, when considering integration of the disciplines, Porter (2010) purports that preference should be given to theological claims over psychological claims when there is a contradiction between those claims, or in cases when both could be equally true. However, in these instances of contradiction, it should be understood by both disciplines that the truth they are putting forth is a tentative one, and therefore the determination of which claim is essentially true is best deferred. This does not mean that theological claims do not still have a greater authority than psychological ones; it just means that the determination of which one is ultimately true can also be suspended.

Although maintaining that preference should be given to theological claims, Porter (2010) acknowledges that psychological claims about human nature should still be considered in reference to these theological truths, so that if the psychological claims challenge those of Theology, the theological claim can be adjusted, if necessary. In this way, Psychology is allowed to have an influence on Theology, but not to the detriment of Theology's ultimate authority in determining what compromises natural reality and truth. There are times when Psychology can add knowledge in a subject area that Theology cannot equally do, in which instances Psychology has "full reign" (Porter, 2010, p. 11).

His view on integration, therefore, is that the field of Psychology can add knowledge and research, which can lead to theological claims being amended, but this is within the boundaries of theological interpretation remaining more authoritative. Even though the interpretation of Scripture can be fallible, Porter (2010) still sees the interpretation thereof to contain "derivative authoritative advantage", (Porter, 2010, p. 12) because Scripture remains infallible. The person interpreting the Scripture need not have any specific formal training or qualification to do so, because the Holy Spirit is understood as providing divine and, by implication, irrefutable truth (Porter, 2010). In this way, one's "best understanding" of

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theological or biblical truths should have authority over the “best understanding” of psychological truths in cases where there is any incongruity between the two (Porter, 2010, p. 12). Both disciplines have recognised roles in the case of integration; therefore, according to the author, Theology maintains its ultimate authority, yet Psychology contributes to Theology’s understanding of human nature.

As mentioned, Porter’s (2010) position leads to much debate, from psychologists and theologians alike, regarding the hierarchical structure of his integration model. The arguments put forth by the responders to this model will now be discussed.

Sandage and Brown (2010), the former a psychologist, and the latter, a biblical scholar, respond to Porter (2010) from an egalitarian, relational perspective. The focus of these authors (Sandage & Brown, 2010) is on the relational dynamics that influence the efficacy of integration, rather than a singular focus on the authority or accuracy of the theoretical knowledge that each discipline brings. Firstly, Sandage and Brown (2010) challenge Porter’s (2010) assumption that psychologists and theologians become anxious about integration leading to defensiveness, by indicating that this is a generalisation which does not apply to all psychologists or theologians. There is concern that the hierarchical model can undermine the potential for professionals to collaborate effectively and to build trust within these collaborative relationships.

Secondly, these respondents (Sandage & Brown) challenge Porter’s (2010) position that theological claims accurately reflect the ultimate and infallible authority of God. Sandage and Brown (2010) state that both the disciplines of Theology and Psychology put forth claims of truth formed from interpretation about the sources that they are studying – Theology does not have the ability to speak directly on God’s behalf and Psychology cannot speak with sovereign insight into human nature. Biblical truths must be recognised as being embedded within the cultural, historical and social contexts that they originally occur in, but are then interpreted by theologians for the current context in which they speak. This implies that theologians often make interpretations about Scripture which may not be irrefutable. The claims put forth by each professional are, furthermore, determined and discussed within professional communities, the members of which are not always united in their interpretation of these claims, which undermines the infallibility of both disciplines.

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Sandage and Brown (2010) state that an egalitarian approach to integration is more favourable than a hierarchical one, because the dynamics of power and authority differ between the two approaches. Hierarchical relationships are ones where there is a greater probability of oppression for the party that has less power, whereas there is space within egalitarian relationships for the constructive discussion of differences. Sandage and Brown (2010) do not believe that the presence of anxiety in relationships should lead to a power differential in order to reduce that anxiety. Rather, they believe that the presence of anxiety can lead to growth in relationships by means of maturity, humility and integrity in both parties. When this takes place, then both parties can recognise one another's perspectives and make room for these perspectives. Sandage and Brown's (2010) position regarding integration is that egalitarian relationships are more useful in creating dialogue between disciplines. Through this dialogue, there will be a valuable quest in determining the concept of "truth", or the utility of certain claims, in a mutual collaboration towards this end.

Entwistle and Preston (2010) offer a reply to Porter (2010) as well, and argue the premise that "well-grounded theological claims have a higher authority than well-grounded psychological claims" (Porter, 2010, p. 9). The assertion that a fallible theological interpretation has more derivative authority than a fallible interpretation from another subject matter, due to the former's origin in God, is an assertion that Entwistle and Preston (2010) challenge. According to these authors, this is because the methods that are used to generate interpretations and hypotheses must be carefully evaluated in order to ensure epistemic advantage and accuracy. In this way, some sciences are empirically able to test hypotheses, which gives them an epistemic advantage over the disciplines that cannot test hypotheses. Often times, it is psychological science that is able to test hypotheses, whereas Theology does not have direct access to God in settling interpretative debates or quandaries. Thus, Entwistle and Preston (2010) dispute Porter's (2010) claim that theological claims have authority over psychological claims, because it is "as if God himself is on one side and the human psychological community (etc.) on the other....." (Porter, 2010, p. 10 as cited in Entwistle and Preston, 2010, p. 29). Similarly, Entwistle and Porter (2010) highlight the fact that one's interpretation of theological or Scriptural texts is subject to fallibility and therefore cannot be assumed to be given automatic superiority over opposing views in times when those opposing views carry significant epistemic validity. Although Entwistle and Preston (2010) concur that Scripture informs a Christian worldview, and that Christian theology challenges secular assertions that contradict a Christian worldview, they maintain that effective integration does

not automatically give theological claims ultimate authority in times where there is a conflict between Theology and other disciplines.

As can be seen from the models of integration, and the debates around biblical supremacy provided in this section, the subject of integration is one containing prolific opinion. It is necessary for this state of affairs to be acknowledged, because if there is much debate on integration within academic writing, one can expect that there will be equal debate within academic institutions. Although this section has considered some historical factors that have informed the integration of religion, spirituality and mental health, there has been much progression in these fields in recent times. Section Four will consider the international landscape of religion, spirituality and mental health, with Section Five looking at the national landscape.

### **Section Four: The International Landscape of Religion, Spirituality, Mental Health and Psychology**

Although the historical relationship of religion, spirituality and science may be one that has been fraught with periodical tension, there has been progression in how these disciplines interact. It cannot be denied that religion is one of the factors that influences society, which is becoming more evident in the public sphere (Habermas, 2008). Therefore, the subject of how best to integrate these dimensions of society into holistic treatment gains momentum and research attention. These questions are not ones that have only been asked in the last decade as publications dating back to 1980 had already begun to evaluate the role of values in psychotherapy. The research on values in psychotherapy has dove-tailed with research examining how psychologists deal with or perceive religious and spiritual dimensions, both for themselves and for their clients.

To this end, research into the role that religion and spirituality have played in the personal and professional realms of psychologists has been the focus of much international research, in a pursuit to understand its role in the science of Psychology (Shafranske, 1996). The foundational work of Ragan and Malony (1980) in determining the values of psychologists has led to continued research and progression in the field. A review of some of this formative work will be discussed in order to provide the context for the current international landscape of religion, spirituality and psychology.

### **Past Studies: Values Debate**

As mentioned, whether or not there is a disparity between the levels of religiosity in the general public in comparison to psychologists in clinical practice is a question that has been under review since the 1980s. Ragan and Malony (1980) undertook research to determine the levels of religiosity present in psychologists in comparison to the general population, and the nature of the religiosity that was present in psychologists. The research participants were randomly selected from the American Psychological Association registry of 1975, and 522 questionnaires were completed for use in the study. The results showed that, although the psychologists showed much lower levels of religiosity than the general population as a whole, 47% of the participants reported some church attendance with 27% attending church at least half or more of the Sundays in a year. This would suggest that one cannot simply assume, as a generalisation, that psychologists are irreligious, but rather that there is a high percentage of psychologists in this sample that acknowledge and engage in some form of religious belief, albeit typically non-traditional in nature. This survey also asked some detailed questions about the nature of the psychologists' religiosity and how it impacts on their approach to psychotherapy. The results showed that the psychologists for whom religion was personally relevant, were far more likely to consider the salience of religiosity in their work than the psychologists who were not religious. In fact, 64% recognised their beliefs about religion as being related to their approach to treatment and psychotherapy; with only 15% showing concern that the two disciplines were conflictual.

Bergin and Jensen (1988) conducted a national survey in the USA that was undertaken to determine values that various mental health professionals deemed to be of importance to the field in general, and to psychotherapy (Jensen & Bergin, 1988). The results published from this survey showed some interesting trends that have paved the way for further research. In this 1988 survey, clinical psychologists, marriage and family therapists, social workers and psychiatrists were sampled. Participants were asked to complete questionnaires that contained "value themes", and to rate these values according to the importance they held in two main criteria. The first criterion was the extent to which the value was "important for a positive, mentally healthy life-style" (Jensen & Bergin, 1988, p. 293) and the second criterion was the extent to which the value was important in guiding and evaluating psychotherapy. The participants could rate their levels of agreement according to levels of agreement or disagreement for the first criterion, and according to the frequency at which the criterion was used to guide and evaluate psychotherapy with clients.

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Although publications prior to this study had indicated that psychotherapists should be value-neutral (Jensen & Bergin 1988), the results showed that the participants showed high levels of consensus on basic values that are both central to mental health, and to the guidance and evaluation of psychotherapy. These values included feelings of worth, deepened self-awareness, adaptive coping strategies, finding fulfilment in work and good physical health habits. What was obvious from the responses was the correlation between the therapist's own life-style and how this influences the therapist's perception of what constitutes mentally healthy behaviour. For example, religious therapists were more likely to rate religious values as pertinent to both mental health and psychotherapy.

It was, however, the value themes that referred to spirituality/religiosity, and sexuality, that showed the least consensus among the participants of the study as to the implications of these factors for mental health. Therefore, as Jensen and Bergin (1988) state in their concluding comments, it is within these very areas that therapists should tread the most tentatively when treating their clients, to ensure that values are respected.

In Bergin and Jensen (1990), the results of the above study were further extrapolated and analysed in order to provide a greater understanding of the findings within the sphere of the value theme of religion and spirituality. Within this survey, the therapists' own religious preferences were also measured in relation to the general American public. According to a Gallop poll of the American public in 1985, 91% reported to be religious whereas only 80% of the professional sample surveyed reported to be religious; thus a somewhat lower percentage. Of significance in this survey was the finding that the professional sample showed a much higher level of religious attendance and life-style commitment to religion than what had been expected. 77% of the professionals surveyed stated that they try to live their lives according to their religious beliefs, and 41% said that they attend some form of religious service on a regular basis. The general public showed statistics of 84% and 40% on these two factors respectively which does not differ much from the professional sample. Although professionals may show a higher involvement and interest in religion than what had been expected in this survey, the results showed that the professionals generally expressed their religious interest in more unconventional ways. This unconventionality was demonstrated through the survey by the fact that only 44% of the professionals recognised the importance of the value of having a "religious affiliation in which one actively participates" (Bergin & Jensen, 1990, p. 6). There were also differences between levels of religiosity amongst the groups of professionals that were surveyed. The marriage and family therapists showed the highest levels of religiosity, followed

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by the clinical social workers, then by psychiatrists; with clinical psychologists showing the lowest levels of religiosity amongst the professionals.

Although religiosity was established amongst these professionals, it did not actually automatically transfer into a belief that religious matters are central to the treatment of, and psychotherapy with their clients. Only 29% of the professionals found religious matters to be valid in the course of treatment and psychotherapy, which is significant when considering that 80% of them had stated that they have their own religious preference. Therefore, a personal religious preference did not necessarily translate into a belief that integration of religious beliefs is valuable to the treatment of clients. As mentioned in Jensen and Bergin (1988), there is little consensus among professionals as to the implications of religion on mental health, and the place of religiosity in treatment and psychotherapy. In 1985, however, two thirds of the American population either identified religion as being the single most important factor of their lives, or a very important factor of their lives. This means that two thirds of the USA population at that time recognised religion as being a foundation on which their lives gained meaning, a factor which cannot be dissociated from effective psychotherapy. This may well imply that the general population at that time would have had a preference for their religious and spiritual beliefs be integrated into the therapeutic process. However, judging from the data that Jensen and Bergin (1988) obtained, the psychologists did not account effectively for this potential preference. Therefore, Bergin and Jensen (1990) refer to a “religiosity gap” as the danger which can begin to develop when the religious dimension of clients is not factored into the therapeutic process. When psychotherapy is not sensitive to religious and spiritual matters, and when the centrality of religious factors is not taken into cognisance for certain clients, then the therapist is missing the essence of who the client is. The client’s beliefs, values and symptoms may be mistakably pathologised, and the process of psychotherapy may be stunted through this “religiosity gap”.

A study by Shafranske and Malony (1990) focusing solely on the religious orientations and practices of clinical psychologists examined similar concepts as the above study (Bergin & Jensen, 1990). In the Shafranske and Malony (1990) survey, clinical psychologists were asked to complete surveys that measured various factors, for example their personal religious and spiritual orientation, the extent to which they used religious interventions in the course of psychotherapy, their attitudes towards religiosity, and the training they had received in relation to religious matters and mental health. Some of the results of this study have been summarised by Shafranske and Malony (1990) in a table below:

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*Table 1*

*Summary of Findings of Shafranske and Malony (1990) - Personal Religious and Spiritual Orientation*

<b>Participants who:</b>	<b>Percentage</b>
Endorsed a personal, transcendent God orientation	40%
Viewed religious beliefs as desirable for people in general	53%
Reported spirituality as personally relevant for them	65%
Reported that “my religious or spiritual development has emerged out of my sense of personal identity”	54%

When it came to religious affiliation and involvement in organised religion, however, the results were similar to those of Ragan (1980), in that psychologists generally did not exhibit high levels of involvement with such institutions. Therefore, although the above table would suggest that psychologists in this study (Shafranske & Malony, 1990) might find value in religion or religious beliefs for both themselves and their clients, they do not necessarily align themselves with institutions of religion. Furthermore, this study showed that 51% of the psychologists characterised the nature of their spiritual and religious beliefs as being “alternative” and not part of “organised” religion.

On the relevance of religion for clinical practice, the findings showed that the psychologists who were surveyed generally found relevance in religious and spiritual matters for their clients. In fact, 74% disagreed that the domain of religion and spirituality falls outside the scope of their practice, especially, because it was estimated that about 1 out of every 6 of their clients present with a problem that has some kind of religious or spiritual basis. With such a majority of clinicians agreeing that religious and spiritual issues are pertinent to clinical practice, it is concerning that 67% agreed that clinicians do not actually possess adequate knowledge or skills in the realm of religion, spirituality, and mental health.

Shafranske and Malony (1990) also measured the degree to which these clinical psychologists used religious interventions in clinical practice, as well as the nature of these interventions. The table below summarises some of these results:

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*Table 2*

*Summary of Findings of Shafranske and Malony (1990) - The Use of Religious Interventions in Clinical Practice*

<b>Participants who:</b>	<b>Percentage</b>
Agreed that the religious backgrounds of clients influence the course and outcome of psychotherapy	64%
Regarded it appropriate for psychologists to know the religious backgrounds of their clients	87%
Supported the use of religious language, metaphors and concepts in psychotherapy	59%
Conceded that it was inappropriate for psychologists to use religious Scripture or texts while conducting psychotherapy	55%
Agreed that it was inappropriate for a psychologist to pray with a client	68%
Disagreed that it would be appropriate for a psychologist to recommend to a client that they leave their religion if they assessed it to be a hindrance to their psychological growth	73%

The participants in this study were asked to report on the actual religiously based behaviours that they had engaged in during the course of psychotherapy; the table below summarises these results as reported by Shafranske and Malony (1990):

*Table 3*

*Summary of Findings of Shafranske and Malony (1990)*

<b>Behaviour</b>	<b>Performed</b>	<b>Not Performed</b>
Know clients' religious backgrounds	91%	9%
Pray with a client	7%	93%
Pray privately for a client	24%	76%
Use religious language or concepts	57%	43%
Use recommended religious or spiritual books	32%	68%
Recommend participation in religion	36%	64%

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The data here suggests that psychologists were far less comfortable to engage with explicitly religious behaviours; for example, pray with a client, than engaging in implicit religious behaviours; for example, praying privately for a client. This is most likely because there may be perceived ethical dilemmas around scope of practice and what psychologists feel the domain of their professional boundary allows them to do. What became obvious in Shafranske and Malony's (1990) analysis of their data was that there was a positive correlation between affiliation and participation in religion with the performance of more explicit religious interventions. Furthermore, the higher the psychologist scored on personal religiosity on the Batson and Ventis three-dimensional model of religiousness (Batson & Ventis, 1983 as cited in Shafranske & Malony, 1990) the greater the likelihood that the psychologist would score highly on levels of confidence in their competence to deal with religious issues with their clients. This confidence was not based on the extent of their training in matters of religion, spirituality and mental health; in fact, only 12% of the surveyed psychologists reported having received such training in either undergraduate or graduate programmes. Rather, their confidence in dealing with the religious issues that clients presented with was based on the psychologist's own personal religious orientation, and their comfort in addressing religious issues.

In a United Kingdom based study, Crossley and Salter (2005) found a similar result in that the extent to which psychologists inquired about the spiritual beliefs of their clients was primarily influenced by their own personal experiences or personal beliefs about religion and spirituality. This is a finding that should be carefully considered, because being religious oneself does not necessarily mean that one is competent in the integration of psychology and religion, an area which perhaps requires specialised training.

The results of the studies cited above are interesting, because they provide a reference point in measuring how perceptions may have shifted over time. However, considering that some of these studies were conducted in the 1980s and 1990s, there is a requirement to consider what the more current landscape of perceptions reflects. To this end, Delaney, Miller, and Bisono (2013) recently undertook a similar study, in which the religiosity and spirituality of clinician members of the APA was reviewed. Some of the questions that this survey included were:

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- *How important is religion in your own life? (Very, Fairly, Not Very)*
- *Have you ever believed in God? (Never, Yes in the past but not now, Yes and continue to do so)*
- *How often during the past year have you prayed? (Never, Rarely, Once/twice a month, Once/twice a week, Almost daily, Once a day or more)*
- *What do you personally believe about the effects of religion, in general, on mental health? Do you think that being religious is most likely to be: (Harmful to mental health, Irrelevant to mental health, Beneficial to mental health)*
- *How often do you inquire about or assess your clients' religion or spirituality? (Never/rarely, Sometimes, Often, Always)*
- *How often are spiritual or religious issues relevant in the treatment that you provide? (Never/rarely, Sometimes, Often, Always)*

As one can see from the types of questions posed in this survey, the religion and spirituality of the participants was measured, as well as their perceptions of how important their clients' religion and spirituality is to mental health, and ultimately to their psychotherapeutic treatment. The results of this study included a number of noteworthy findings. Firstly, psychologists within the APA sample still show lower levels of religious affiliation than the general population. In fact, psychologists were twice more likely to be atheist, three times more likely to state that religion was not central to their lives, and five times more likely to deny any belief whatsoever in God. The psychologist sample was also less likely to engage in overtly religious activities for example prayer, or being integrated into a religious congregation, than that of the general population. Catholic and Protestants were the minority group among the psychologists, with Jewish psychologists being more dominantly represented. Of further interest was that 27% of the psychologists who were surveyed reported a loss of personal faith in God, which is a noticeably higher statistic in comparison to the general population, which only reported a 4% occurrence of a loss of faith. There was no opportunity within the survey to expand on why they had lost their faith, or to extrapolate on possible reasons for this statistic.

Although the statistics in Delaney et al. (2013) showed that the psychologists were considerably less religious in their personal beliefs and orientation in comparison to the broader population, the statistics further showed that the psychologists did not necessarily have a negative perception of religion when it came to the treatment of their clients. More than 80% of the psychologists deemed religion to be advantageous to mental health, investigated themes

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of religion and spirituality in their clients' presenting problems, and saw these factors as significant to the treatment of these clients. There are, of course, limitations to this study specific to the sample of psychologists surveyed versus the general population. These factors include the fact that the average age of the psychologist participants was 57, they had higher levels of education than the general population, and were less racially and ethnically diverse than the general population. Furthermore, the participants who volunteer to take part in surveys such as this are more likely to already be involved in some form of religious group, or to perceive religion as important either to themselves or to their clients, which may inflate the statistics. The results from this study (Delaney et al. 2013) concerning the levels of religiosity in psychologists do not differ significantly from those in the other studies mentioned (Ragan, 1980; Bergin & Jensen, 1990; Shafranske & Malony, 1990). This study has implications for the field of Psychology, as it highlights an obvious disparity in how the salience of religion and spirituality is perceived amongst psychologists in comparison to the general population. The fact that 83% of the psychologists in the Delaney et al. (2013) study acknowledged the benefit of religion for mental health has implications for the profession. These implications centre largely on the place of religion and religiously-based issues within the scope of Psychology. The DSM-IV had introduced a V-Code for the diagnosis of religious and spiritual problems that become apparent within a mental health context. However, according to Shafranske and Malony (1990), 85% of their psychologist sample reported not possessing the necessary training and education to provide treatment to clients with such V-Code religious problems, except to refer them to other professionals. This leaves much uncertainty for professionals and creates the impression that there is a chasm between psychology and religion, and that religious patients cannot be effectively treated within the context of psychotherapy.

Although this survey provides some interesting information, it raises some questions too. For instance, just because psychologists can acknowledge that religion and spirituality is important in how they conceptualise and treat their clients does not necessarily mean that these psychologists are trained to use or understand the information provided to them in a way that is beneficial to the mental health of their clients. It also does not imply that psychologists know how to assess accurately the presence of religiously based difficulties and integrate this into the overall clinical management of a case.

Some of these quandaries were reviewed by researchers who built on the above cited publications by furthering the study of religion, spirituality and Psychology. Freud (1918 as cited in Peteet et al., 2016, p. 1098) used the German term *Weltanschauung* to describe the

“intellectual construction which gives a unified solution to all the problems of our existence in virtue of a comprehensive hypothesis”. In essence, therefore, *Weltanschauung* refers to the worldview that a person holds, which is supported by Bilgrave and Deluty (1998, p. 329) who explain this same term, *Weltanschauung*, “to refer to the existential, explanatory belief system, picture or worldview of the universe that a culture as well as individuals hold”. This *Weltanschauung* becomes the driving force behind decisions, behaviour and meaning-making. The authors of this study (Bilgrave & Deluty, 1998) discovered that the psychologists surveyed held personal *Weltanschauungen* that contained strong religious and spiritual beliefs that were important to the professionals in how they lived their lives and how they approached the practice of psychotherapy. This study highlighted a rather unique finding, though, in the fact that the psychologists had formed dual *Weltanschauungen*. The one that was developed within the context of their religious communities encouraged them to perceive the world according to religious principles, but the *Weltanschauung* formed within the sphere of professional training was one in which more humanistic and scientific models for understanding humankind were drawn upon. The result was that the psychologists felt a deep challenge in reconciling these divergent perspectives on existential reality.

Case and McMinn (2001) acknowledged the immense stress that this dilemma, and the general stress of being a psychologist, can exert on professionals. The coping strategies that psychologists employ to deal with these high levels of stress and tension were researched by Case and McMinn (2001), to determine the correlation between spirituality, coping, and well-being. The study found that many psychologists depended primarily on their religious beliefs and religious practices, for example prayer; meditation, and attending religious services, to mitigate the powerful stressors inherent in their work. These authors subsequently suggested that religious coping strategies be taught to graduate students as an option for dealing with stress, and that religious graduate students entering their training programmes be encouraged to make use of their religious coping strategies in reducing stress.

As already cited, there have also been studies undertaken in the United Kingdom along these subject areas. Another such study was the one by Baker and Wang (2004) who reviewed the experiences of Christian clinical psychologists who were employed within secular institutions. The rationale for Baker and Wang’s (2004) paper is, in part, formed by the authors having frequently been asked the question “How can you be a psychologist and a Christian?” (Baker & Wang, 2004, p. 126). The nature of that question led the authors to assume that lay people consider the values of Psychology and Christianity to be dissonant. Their research

showed that there are numerous ways in which the values of who the participants were as Christians and who they were in their professional capacity had converged and diverged. It was not a static process, but was a multidimensional one that fluctuated over time, and through the experiences of the research participants.

As previously mentioned, a United Kingdom based study by Crossley and Salter (2005) looked at clinical psychologists' experiences of addressing spirituality in therapy. The rationale for this study stemmed from the authors having perceived the position of spirituality within the field of clinical Psychology to be an ambiguous and ill-defined one; Mainstream academic Psychology still seemed to place limited emphasis on the role of spirituality, and therefore research on this subject domain is similarly sparse. Crossley and Salter (2005) state that there is little empirical research being conducted to investigate how clinical psychologists approach spirituality. Therefore, their study aimed to research this question more directly, through the use of semi-structured interviews with clinical psychologists, which were then analysed by means of grounded theory methodology. There were two core categories found by these authors, the first of which was "spirituality as an elusive concept", with the second "finding harmony with spiritual beliefs".

The core category of "spirituality as an elusive concept" was discussed in two principal ways, which were represented by two sub-categories. Firstly, the diversity of spirituality (Category 1) was seen to add to its elusiveness, and, secondly, that spirituality was a concept with which the field of clinical psychology was not actively engaging, a contributing factor for Category 2.

Relating to the diversity of spirituality, the clinical psychologists interviewed in the Crossley and Salter (2005) study all acknowledge the fact that spirituality is understood, conceptualised and defined in a myriad of ways. There was a distinction between what most participants understood as "religion" in comparison to spirituality, the former being more restrictive and the latter being more expansive in nature. Participants were aware that spirituality and religion can be linked to a large degree for some people, generally the concept of spirituality was understood by participants as being broader than religion, and encompassing more elements, for example an individual's sense of self can be seen as spiritual. With this broader definition of spirituality, however, came the consensus from participants that the term spirituality should have some kind of boundary attached to it, so that spirituality did not become too relativistic.

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When it came to the lack of engagement with spirituality within a professional context, many of the participants stated that they had not been involved in discussions regarding the concept of spirituality, or even given thought to this concept, at any point in their careers. It was also found that training around the concept of religion, spirituality or the integration thereof within their professional practice was absent from these research participants' training courses. In this study (Crossley & Salter, 2005), there were three main themes found around the reason for clinical psychologists' lack of engagement with spirituality. Firstly, some of the participants expressed a strong discomfort when spirituality is discussed, due to it being a sensitive subject for many people, one that is seen as a personal and private matter. In this particular instance, the topic of religion is perceived as more uncomfortable for some than spirituality, because religion can so often be associated with division. Within the psychotherapeutic context, the participants who reported not inquiring about spirituality from their clients did so because spirituality was not a significant factor in their own lives, which accords with the findings discussed earlier. Apart from these factors, the psychologists mentioned that there is a lack of nomenclature with which to discuss effectively these concepts with clients. The participants stated that most of the terms used to discuss spirituality as a broad concept are still associated with religion, which was experienced as inhibiting.

The second core category (Crossley & Salter, 2005) was "finding harmony with spiritual beliefs". Participants were questioned as to how they dealt with clients who held spiritual or religious beliefs. As mentioned earlier in this chapter, psychologists must act in a manner that is in a client's best interest. It is therefore not surprising that the participants in this study stated that their primary concern and aim is to conduct themselves in a way that is "aligned with and actually in harmony with the particular beliefs that are held" (Crossley & Salter, 2005, p. 304). This aim was attained in two fundamental ways; "understanding beliefs" and "respecting beliefs". In order to understand their clients' beliefs, the research participants would either inquire or assess the beliefs directly without waiting for the clients to mention their beliefs, or alternatively, the participants would wait for the clients to raise the subject of their beliefs before bringing them into the therapeutic discussion. On waiting for the clients to raise their beliefs first; some of the participants felt that clients would raise spiritual beliefs spontaneously if these beliefs were important to them, and that the psychologist did not have to inquire about it.

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When participants were focused on “respecting beliefs”, they judged this was best achieved by being non-judgemental about those beliefs, and being empathic instead. However, this was more difficult for the psychologists in situations where they found that the clients’ spiritual beliefs or understandings were contributing to their psychological symptoms or their anguish. When this was the case, there were three main ways that the participants reported dealing with those situations. Firstly, participants would consider withdrawing from discussing that particular belief in an attempt to demonstrate respect for the client. However, participants felt that, by doing this, they had lost the opportunity to explore the nature of those beliefs with the client. Secondly, the participants would attempt to explore their clients’ beliefs through challenging the client to think in a way that was more congruent with how the participant thought. Lastly, participants would recommend that clients discuss their spirituality or spiritual distress with spiritual or religious leaders so that they could gain that leader’s perspective on the matter.

In considering the implications of their study, Crossley and Salter (2005) state some important findings when it comes to spirituality and the field of Psychology. Obviously, the definitions, opinions and understandings of spirituality are infinite, making it a difficult concept to integrate in the field of Psychology. Therefore, the most useful way to define spirituality is as a complex and multidimensional concept. Once the many divergent aspects of spirituality are clarified and acknowledged, there is a greater probability of the field of Psychology engaging with it (Crossley & Salter, 2005).

As found similarly by Shafranske et al. (1990) and by Delaney et al. (2013), the participants in Crossley and Salter’s (2005) study reported that inquiring about spirituality with their clients was influenced by their own personal experiences, and their beliefs about spirituality and religion. It was not the participants’ clinical training that steered this inquisition, but rather their personal biases, thus demonstrating that personal biases impact on professional practice, as already argued above. The authors therefore suggest that “reflexive considerations” (Crossley & Salter, 2005) should be essential to integrating spirituality with psychology. Shafranske et al. (1990) found that little training was taking place within USA based post-graduate courses on spirituality, religion, and psychology, and this finding was mirrored by similar results in the Crossley and Salter (2005) study. Training in spirituality, religion, and psychology would, therefore, enable psychologists to gain much needed clinical knowledge about these subjects, which, in turn, would inform clinical practice. This would reduce the divergence in how psychologists approach issues of spirituality and religion, because the

training would provide some kind of guideline for inquiring, understanding, and integrating spiritual or religious beliefs in a psychotherapeutic process.

The following section on current studies, as well as Section Four (International landscape, and Section Five, South African Landscape) will provide background and contextualisation for the introduction of the Problem Statement, which will be introduced in Section Six: Implications and Conclusions.

### **Current Studies and Research**

When considering the above research studies, one can see that, in general, psychologists were found to be less religious than the population in which they were surveyed, which has been reflected in the fact that there are very few mainstream psychology texts that review the role of religion and spirituality (Jones 1994). Jones (1994) has posited that psychologists often remain silent and neutral about issues of religion and spirituality when treating their clients, because this is assumed to be the most respectful way to relate to a belief system that the psychologists do not necessarily adhere to themselves. However, the intentional omission of a route of inquiry is, in and of itself, not a neutral stance. Although there may be various attitudes towards religion and spirituality amongst psychologists, it has been well established in research that the search for meaning and the creation of meaning-making systems is integral to existential significance and purpose. Part of this meaning-making is found in religious and spiritual beliefs (Park, Edmondson & Hale-Smith, 2013).

The profession of Psychology has begun to be increasingly cognisant of the role of religion and spirituality when treating clients. This was reflected in the American Psychological Association's 2013 publication of two volumes titled "The American Psychological Association Handbook of Psychology, Religion and Spirituality" (Pargament, 2013). These volumes comprise chapters that review the role and ethical integration of religion and spirituality in clients' worldviews as well as numerous chapters reviewing the belief systems of various faith traditions. The APA created Division 36 which is a special interest subgroup that has psychology, religion and spirituality as its main focus, with an emphasis on advocating further research in the integration of psychology, religion and spirituality. The APA has also included the following principle in the ethical code of conduct for psychologists:

Boundaries of competence: APA

b) Where scientific or professional knowledge in the discipline of Psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have to obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies (APA Ethical code of conduct for psychologists, 2017).

This boundary of competence specifically requires psychologists to be cognisant of professional and scientific knowledge that would deepen their understanding of a client with regard to, amongst others, religious views. Ethical practice for psychologists includes obtaining the training required to integrate these factors into effective treatment so that the importance of these views is not negated by the psychologist.

Not only has the APA published guidelines for the inclusion of religion and spirituality, but the World Health Organisation (WHO) has made mention of spirituality in healthcare too. In 2014, the WHO released a statement regarding spirituality and the treatment of patients when it comes to palliative care. The WHO resolution on palliative treatment included the following phrase:

The resolution considers provision of palliative care to be an ‘ethical responsibility’ of health systems and called on health care professionals throughout the world to fulfil an ‘ethical duty’ to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured. (Vitulo & Puchalski, 2014, p. 988)

This resolution includes the ethical duty and responsibility of healthcare professionals to alleviate suffering within the spiritual realm as well. Therefore, ethical treatment is not restricted to just physical or psychosocial distress, but expands to include a review of possible spiritual distress as being equally important. Naturally, this implies that healthcare

professionals should be adept at both assessing and including spiritual factors in their diagnostic and treatment plans. Not only has the field of Psychology begun to consider these factors, but there has been a substantial focus on spirituality in healthcare in the United States (Koenig, 2012).

To this end, the work of Christina Puchalski and colleagues at the George Washington Institute for Spirituality and Healthcare has produced countless resources and publications for the integration of religion and spirituality to all healthcare fields. These resources have become formative in creating a framework within which Psychology can review integration, and have become widely accepted by many health professions (Cobb et al., 2014). Some of these guidelines will be discussed in this section, due to their potential applicability to integrative practices in a South African context.

### **Guidelines for the integration of religion and spirituality in healthcare**

FICA is a tool that was developed for spiritual assessment of patients by Puchalski (1999). FICA is an acronym for suggested domains of inquiry when taking a patient's spiritual history. The acronym and associated suggested questions are as follows:

F: Faith or Beliefs: Do you consider yourself spiritual or religious? What is your faith or belief system?;

I: Importance and Influence: Is your faith important in your life? What role do your beliefs play when it comes to your health?;

C: Community: Are you part of a religious community? Is this community of support to you, and if so, how?; and

A: Address: How would you like me as your healthcare provider to address these beliefs in your care?.

This tool can be used to gain insight into the value that the patient associates with their religious or spiritual beliefs, and can provide the health worker with information that will guide the ethical treatment of the patient in the light of these beliefs. If the patient answers that they are not religious or spiritual, or that these beliefs are not important to them, and/or that they do not want these beliefs to be addressed in treatment, then the healthcare practitioner ought to respect that position and respond accordingly. This is clearly a different approach to the one

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referred to previously where Jones (1994) described how psychologists remain silent or avoidant of this type of inquiry. Rather, this tool enables a respectful inquiry and directive to the healthcare professional to proceed with a patient's assessment and treatment, relevant to spiritual and religious matters.

Another such tool for the used for the assessment of spirituality and religion is MERIT (King, 2000, p. 61):

M: Member of a church or assembly of worship

E: Existence of a higher being

R: Religious denomination

I: Importance of religion in your life

T: Talk about it further

The healthcare practitioner will ask questions according to the acronym listed above and the patient will be able to answer on the importance of these beliefs by awarding it a value from one to five or from one to ten. If the patient responds in a way that indicates that his/her religious and spiritual beliefs are important for him/her, then the practitioner can proceed by asking how the patient relates those beliefs to his/her health.

Both of these models of inquiry into a patient's religious and spiritual beliefs provide non-invasive questioning and exploration, and will provide information that can be used to ensure the patient's holistic care and treatment.

These above mentioned assessment tools are by no means the only guidelines available for practitioners. Puchalski et al. (2014) developed a model of Whole Patient Care in which the spiritual dimension of this care was extrapolated. This model was developed in order for spirituality to be integrated into healthcare systems, and for these care systems to be undergirded by compassion on the part of the healthcare worker. In this model, spiritual care is seen as integral to the compassionate care of patients, and the facilitation of that care should be addressed through education and training of healthcare workers. Within this publication (Puchalski et al. 2014), the directive is also given to engage in research on spirituality and healthcare throughout the world so that international standards of care and ethical practice can be better improved.

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Puchalski and Larson (1998) published a paper that addressed the necessity for medical students to be trained in holistic patient care through the incorporation of spirituality and religion. It was posited by these authors that the medical school curricula at that time were generally lacking in teaching compassionate patient care, which is inclusive of respecting a patient's religious and spiritual beliefs. With the medical fraternity growing in the knowledge of how spirituality may impact healthcare, Puchalski and Larson (1998) surveyed the medical schools that used this kind of integrative approach to healthcare. They found that faculty members, students and patients had responded positively to this approach and that compassionate care had improved the quality of patient-doctor relationships, and the quality of care to those patients.

In 2014, Puchalski, Blatt, Kogan and Butler published a paper that outlined the National Competencies of Spirituality and Health, which entailed a framework for assessing and understanding spirituality in the education of medical students on a national level. The full list of competencies is available in Puchalski et al. (2014), but for the purposes of this section, the five main competencies will be listed (Puchalski et al., 2014, p. 15 – 16):

1. Patient care: Integrate spirituality into routine clinical practice;
2. Knowledge: Acquire the foundational knowledge necessary to integrate spirituality in patient care;
3. Compassionate presence: Establish compassionate presence and action with patients, families, and colleagues;
4. Personal and professional development: Incorporate spirituality in professional and personal development; and
5. Communications: Communicate with patients, families, and healthcare teams about spiritual issues.

Each of these competencies is accompanied by a detailed list of behaviours, pedagogic methods, and pedagogic assessment points. For example, one of the outlined knowledge areas for competency number 2 is for the medical students to explain how the major faith and religious traditions relate to patient care. Not only should and can this above-mentioned framework be used for medical student training, but it provides a framework of learning points for healthcare professionals in general.

One of the more widely accepted healthcare models developed that allows for the integration of a person's spiritual and religious beliefs is the biopsychosocial-spiritual model (Sulmasy, 2006). A full review of this model will be considered in Chapter Three, as it is one of the theoretical points of departure that is used in this study. This model is used within many healthcare domains to structure the way that practitioners conceptualise the assessment, diagnosis and treatment of patients, and it continues to grow in popularity (Cobb et al., 2014).

From the brief review of a few of the assessment tools, core competencies, curricula frameworks and models for healthcare, it is clear that these tools may give valuable insight into the development of similar guidelines for the South African context, which will be discussed more thoroughly in Chapter Six. Apart from research being undertaken in the United States of American or United Kingdom based institutions, the Centre for the Academic Study of Christian Spirituality (CASCS) at the University of Zurich has generated much research in the area of Spirituality and healthcare in Europe. This indicates that research about the interface of religion, spirituality and health is being produced internationally, which strengthens the necessity for South African research to follow suit.

### **International Research on the Integration of Religion, Spirituality, and Health Care**

In the same way that there has been research conducted on the integration of religion and spirituality into healthcare as demonstrated above, there have also been publications that specify the value of an integrative approach to patient care. The perspectives from which papers are published vary widely, and there is a massive range of topics covered when it comes to religion, spirituality and mental health. As mentioned, the volume of research internationally available on this subject area far outweighs the scope of this study. Therefore, for the sake of brevity, and for the purpose of illustrating the types of publications being produced, a table is included below with some examples of publications that review an integrative approach to mental healthcare from various vantage points, along with the main findings of these studies:

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*Table 4*

*Sample of International Research on the Interface of Religion, Spirituality, and Healthcare*

<b>Author</b>	<b>Publication</b>	<b>Extracts of Main findings</b>
Sharma et al. (2017)	Religion, Spirituality and Mental Health of US Veterans.	- “These findings suggest that, in addition to mitigating risk for mental health conditions, R/S may be linked to positive psychosocial characteristics and outcomes, such as psychological resilience and altruistic behaviours. It is also important to note that not all religious beliefs and practices are positive. For a significant minority, religion and faith may contribute to anger, suffering, guilt and despair, as well as a decline in mental and physical health (Pargament & Lomax, 2013). Prospective studies are needed to disentangle these associations” (Sharma et al., 2017, p. 203).
Mellacqua (2016)	When Spirit Comes to Mind: Furthering Transactional Analysis Understandings of Spirituality in Health and Psychopathology.	- In the concluding thoughts, Mellacqua (2016, p. 12) makes the following statement to illustrate the centrality of religion and spirituality “the spiritual dimension of life is entwined with the human psyche and its psychological, relational, and bodily (including the brain) dimensions”. - The dimension of the spirit must be integrated into transactional analysis understandings of the human

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		<p>condition and wellness versus pathology.</p> <ul style="list-style-type: none"> <li>- Attention should be given to the incorporation of research-based training around religious and spiritual dimensions in the lives of both patients and psychotherapists.</li> </ul>
Moreira-Almedia et al. (2016)	World Psychiatric Association Position Statement on Spirituality and Religion in Psychiatry.	<ul style="list-style-type: none"> <li>- Patients' religious and spiritual beliefs and practices must be included in psychiatric history taking and assessment.</li> <li>- R/S factors and how they relate to the diagnosis, aetiology and treatment of psychiatric disorders must be included in training and professional development.</li> <li>- More research must be done in the area of R/S and psychiatry.</li> </ul>
Sodi and Manju (2014)	Religion and Spirituality as Predictors of Mental and Physical Health.	<ul style="list-style-type: none"> <li>- Religion and spirituality were positively correlated with both mental and physical health for this Indian population.</li> <li>- Health service users increasingly consult with practitioners who use a spiritually inclusive model of assessment and treatment.</li> <li>- Further research is suggested.</li> </ul>
Rosmarin et al. (2013)	Attitudes Towards R/S Among Members of the ACBT.	<ul style="list-style-type: none"> <li>- Participants found to be less religious than general population.</li> <li>- Adequate training can equip practitioners to recognise and explore the links of R/S in clients.</li> </ul>

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		<ul style="list-style-type: none"> <li>- There is a massive need for more research to be done on R/S and CBT so that core clinical competencies can be developed in this area.</li> </ul>
Pearce and Koenig (2013)	CBT for the Treatment of Depression in Christian Patients with Medical Illness.	<ul style="list-style-type: none"> <li>- Religious involvement was correlated with quicker remission of depressive symptoms.</li> <li>- Empirical evidence is provided that demonstrates the efficacy of Christian-CBT (C-CBT) for the treatment of depression in Christian patients.</li> <li>- More research is required to consider the efficacy of C-CBT in treatment.</li> </ul>
Brown, Carney, Parrish and Klem (2013)	Assessing Spirituality: The Relationship between Spirituality and Mental Health.	<ul style="list-style-type: none"> <li>- Research shows that people who engage in R/S practices and beliefs show generally lower levels of mental health distress.</li> <li>- It is critical to address and integrate R/S into treating patients with physical, emotional or mental health concerns.</li> <li>- R/S can contribute to psychological well-being.</li> <li>- Further research is required in the field of R/S and mental health.</li> </ul>
Koenig (2012)	Religion, Spirituality and Health: The Research and Clinical Implications.	<ul style="list-style-type: none"> <li>- Religious and spiritual beliefs in mental health and general health of patients are used to make sense of illness as shown by much research.</li> <li>- Patients with higher levels of R/S show better mental health and</li> </ul>

		<p>adaptation skills than those with lower levels of R/S.</p> <ul style="list-style-type: none"> <li>- This correlates positively to better general health.</li> <li>- It is of absolute importance that practitioners in healthcare integrate a patient's R/S beliefs to ensure optimal patient care that focuses on the body, mind and spirit.</li> </ul>
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When reviewing the international landscape of research that has spanned the past decades, it is clear that there has been an increased focus on the role of religion and spirituality in society, in professionals' personal lives, and in the sphere of healthcare. This has caused a proliferation of research that indicates that religion and spirituality should not be discounted as a central component of human experience. Although the valence of religion and spirituality should be considered and reviewed, it should not be automatically assumed that religion and spirituality are redundant in the holistic and compassionate care of people in healthcare settings.

**Section Five: The South African Landscape of Religion, Spirituality and Mental Health**  
**(Psychology)**

With South Africa being a pluralistic society that is idiosyncratically multicultural, there is an inherent need to be cognisant of, and sensitive to the beliefs and practices that embody this country. Within the socio-political history and context of South African society, there is a fundamental requirement of law for citizens to be respectful of difference, and to steer away from discrimination. This is a stance that should extend to cultural, religious and spiritual difference too. To gain insight into how these religious and spiritual factors are impacting various South Africans, it is necessary to review literature that is representative of the faith traditions within this country.

Although there is a considerable amount of internationally based research available on this subject field, there is comparatively little available research specific to the South African

context. A review of some of the literature that is specific to the South African context is essential to this study, and will therefore be reviewed in the next section. Similarly to Section Four, it is outside the scope of this study to include all sources of information applicable to this topic, and therefore only the literature most applicable to this PhD study will be reviewed.

### **South African Based Studies on Religion, Spirituality and Mental Health**

In the general household survey published in 2001 (Statistics South Africa, 2001) it was reported that 79.8% of South Africans reported to be predominantly Christian. The term Christian was used to denote a wide array of denominations, churches, and traditional religious groupings, it must therefore be noted that “Christian” in the context of this survey is inclusive of various forms of Christianity. Similarly, in the general household survey published in 2015 (Statistics South Africa, 2015), 85.7% of South Africans reported to be Christian. Therefore, not only is the majority of South African citizens Christian, but there was an increase of 6.2% in the reported rate of Christianity between the two surveys. With 86% of the South African population affiliating with Christianity, and 5.4% professing to following ancestral, tribal, animist or other traditional religions, the discussion of religion and spirituality becomes a valid and applicable one. It follows, then, that the impact of religion and spirituality on the field of mental health in South Africa ought to be considered.

South Africa’s context is also one where legislation and ethical guidelines for practice are the framework upon which healthcare professionals base their conduct. For religion and spirituality to be a construct that finds its way into healthcare practice, the overarching model of integration ought to be one that is congruent with legislative and ethical requirements. Therefore, a brief review of these requirements, as they are applicable to healthcare practice, is provided next.

### **South African Legislative and Ethical Parameters for Practice**

#### **- *Health Professions Act 1974, and The Health Professions Council of South Africa***

To consider the ethical guidelines for the practice of Psychology in South Africa, we must understand the statutory regulations as stipulated by the Professional Board for Psychology, and the Health Professions Council of South Africa (HPCSA). When it comes to

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the Health Professions Act, 1974 (Act no. 56 of 1974) on the ethical rules of conduct for practitioners registered under the Health Professions Act, 1974, there are clear requirements on how psychologists and healthcare professionals should engage with clients. Throughout the Act, the themes of beneficence, fidelity, responsibility, justice and respect for people's dignity are as clearly prescribed as they are in the APA guidelines. A discussion of the entire Act is outside the scope of this literature review. However, for the sake of outlining what will inform some of this research endeavour, I will mention the more salient sections of the Act. There are a few statutory guidelines that are stipulated for psychologists, which are as follows (Health Professions Act, no. 56 of 1974):

- Section 10 (1): A psychologist shall, in all his or her professional activities, respect the dignity and human worth of a client and shall strive to preserve and protect the client's fundamental human rights.
- Section 10 (2): A psychologist shall respect the right of a client to hold values, attitudes, beliefs and opinions that differ from his or her own.
- Section 10 (3): A psychologist shall recognise a client's inalienable human right to bodily and psychological integrity.
- Section 12 (1): A psychologist shall not impose on a client, an employee, a research participant, student, supervisee, trainee or any other person over whom he or she has or had authority any stereotypes of behaviour, values or roles relating to age, belief, birth, conscience, colour, culture, disability, disease, ethnic or social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation, socio-economic status or any other factor prohibited by law.
- Section 12 (2): A psychologist shall not unfairly discriminate on the basis of age, belief, birth, colour, conscience, culture, disability, disease, ethnic or social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation, socio-economic status or any other factor prohibited by law.
- Section 14: A psychologist shall not behave in a manner that is harassing or demeaning to persons with whom he or she interacts in his or her work on the basis of factors such as those persons' age, belief, birth, colour,

conscience, culture, disability, disease, ethnic or social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation or socio-economic status.

- Section 15: A psychologist shall take all reasonable steps to avoid harming a client, an employee, a research participant, student, supervisee, trainee or other person with whom he or she works, including harm through victimisation, harassment or coercion.

### ***- The South African Constitution, Act 108 of 1996***

The South African Constitution, Act 108 of 1996 is another piece of legislature that all South Africans are required to adhere to. The South African Constitution, Chapter Two, the Bill of Rights, section 15 states:

15. (1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion.

The applicability of the South African Constitution is a requirement of all practitioners and citizens to respect people's right to religious freedom to the extent that this right does not infringe on any other constitutional rights.

### ***- Mental Health Care Act 17 of 2002***

The Mental Health Care Act considers the rights of mental health users and the responsibilities of care provided by healthcare practitioners. This includes the following stipulations:

#### 8. Respect, human dignity and privacy

- (1) The person, human dignity and privacy of every mental healthcare user must be respected.
- (2) "Every mental healthcare user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life" (Mental Health Care Act 17 of 2002, p. 11).

**- *White Paper on the Transformation of Higher Education in South Africa, NOTICE 1196 OF 1997 Education White Paper 3***

This white paper looks at the role that higher education institutions have in redressing the underlying values of education that may be rooted in the country's oppressive past. The role of higher education is championed in this white paper as being an avenue through which modern multicultural South Africans can be aligned with current societal needs. To this end, the following goals are put forth:

- To improve the quality of teaching and learning throughout the system and, in particular to ensure that curricula are responsive to the national and regional context;
- To promote the development of a flexible learning system, including distance; education and resource-based learning based on open learning principles;
- To secure and advance high-level research capacity which can ensure both the continuation of self-initiated, open-ended intellectual inquiry, and the sustained application of research activities to technological improvement and social development;
- To promote and develop social responsibility and awareness amongst students as to the role of higher education in social and economic development through community service programmes;
- To produce graduates with the skills and competencies that build the foundations for lifelong learning, including critical, analytical, problem-solving and communication skills, as well as the ability to deal with change and diversity, in particular the tolerance of different views and ideas (White Paper on the Transformation of Education, 1997, p. 10).

**- *The South African Charter of Religious Beliefs and Freedoms (SACRRF)***

According to the SACRRF (2010, p. 4) this charter “defines the freedoms, rights, responsibilities and relationships between the ‘State’ of South Africa and her citizens concerning religious belief”. The charter delineates what freedom of religion entails through the following explanation (SACRRF, 2010, p. 4):

These (rights) include the right to gather to observe religious belief, freedom of expression regarding religion, the right of citizens to make choices according to their convictions, the right to change their faith, the right to be educated in their religion, the right to educate their children in accordance with their philosophical

and religious convictions and the right to refuse to perform certain duties or assist in activities that violate their religious beliefs.

The above stipulated legislature, and ethical practices are only a sample of South African law. The ability to quote all sections of all legislation pertaining to religion, spirituality, discrimination and education is beyond the scope of this study. However, from the legislation above, it is abundantly clear that respect, freedom of religion and religious expression, as well as the right to equality versus discrimination is interwoven throughout. If healthcare practitioners are to practice with ethical astuteness, it is essential for these legislative requirements to be taken into consideration.

**South African Research**

Over the last decade there has been an increase of South African based studies conducted on the place of religion and spirituality in mental health. A review of a small sample of these papers and their main findings is provided in the below table:

*Table 5  
Sample of South African Research on the Interface of Religion, Spirituality and Healthcare*

Author	Title
Peltzer (2005)	Religiosity, Personal Distress and Minor Psychiatric Morbidity among Black Students in South Africa
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Higher levels of religiosity were found in this South African sample than the average for Western societies and American college students.</li> <li>- Some religious variables for example, being a born-again Christian or considering religion as important, correlated to lower levels of Perceived Stress.</li> <li>- Other variables like attendance of church services or frequent prayer were associated with higher levels of Perceived Stress. It was not clear, however, if high premorbid levels of stress were the initial cause of increased attendance to church.</li> </ul>	

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<ul style="list-style-type: none"> <li>- While some factors of religious coping styles were associated with lower levels of psychiatric morbidity, other factors were correlated to higher levels of psychiatric morbidity, which requires more research.</li> </ul>	
Copeland-Linder (2006)	Stress Among Black Women in a South African Township: The Protective Role of Religion
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Engagement in formal religion, and the use of prayer to gain perspective, had a buffering effect on how the participants experienced stress related to racism and work factors, which had a positive impact on their physical health.</li> <li>- The high levels of religiosity found in the sample group may have contributed to the development of resilience in the face of historical oppression.</li> <li>- Qualitative, in-depth research is suggested in investigating the role of religion for black South African women.</li> </ul>	
Temane and Wissing (2006)	The Role of Spirituality as a Mediator for Psychological Well-Being Across Different Contexts.
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- The majority of the participants described spirituality as being a pivotal part of their lives which contributes to their meaning-making. Their connection with a higher-power was a mitigating factor when facing adversity or when they required guidance about life decisions.</li> <li>- Participants desired to exist in an occupational environment where they could express themselves, and their spiritual or religious beliefs with honesty and freedom. This was seen as something that would equip them in reaching their potential in many realms of life.</li> <li>- More research was suggested in how spirituality may be better harnessed within organisations so that people's performances and levels of satisfaction can be enhanced.</li> </ul>	
Monareng (2012)	Spiritual Nursing Care: A Concept Analysis
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Nurses often neglect a patient's spiritual needs due to ignorance about these needs, which is detrimental to holistic patient care.</li> </ul>	

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<ul style="list-style-type: none"> <li>- The participants reported low levels of basic training in the area of spiritual care for patients.</li> <li>- The importance of spiritual care, however, was mentioned by the participants.</li> <li>- In order to provide patients with optimal care, a healthcare practitioner will need to be cognisant of needs on a physical, mental and spiritual level.</li> <li>- Regardless of the personal religious or spiritual beliefs of the nurses, the spiritual care of patients must be prioritised.</li> </ul>	
Welgemoed and Van Staden (2014)	Does Religious Identification of South African Psychiatrists Matter in their Approach to Religious Matters in Clinical Practice?
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Participants who did not identify strongly with a specific religion were more likely to state that religion had little importance when understanding a patient. These participants were less likely to refer a patient to a spiritual leader or a spiritual counsellor.</li> <li>- Participants who indicated that they had no involvement in religious activities were less likely to refer patients for religious or spiritual counselling.</li> <li>- Apart from the two aspects mentioned above, the participants reported that their clinical practice of Psychiatry was not affected by their personal religious or spiritual positions.</li> <li>- The majority of participants in this study expressed a willingness to communicate and collaborate with patients' religious and spiritual role players.</li> <li>- The majority position of the participants also reflected the importance for religion and spirituality to form part of the training of psychiatrists.</li> <li>- The authors state that it is important for psychiatrists and registrars to take their patients' religious and spiritual beliefs into account and to carefully differentiate between harmful versus helpful forms of religious involvement.</li> </ul>	
Mayer and Viviers (2014)	"I Still Believe" ..... Reconstructing Spirituality, Culture, and Mental Health across Cultural Divides
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- People may make sense of life's complexity through spiritual and cultural systems of creating meaning.</li> </ul>	

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<ul style="list-style-type: none"> <li>- Spirituality is not a static concept and undergoes fluctuation throughout an individual's life. At times, spirituality may be associated with positive outcomes for example, inner peace. At other times, however, spirituality may be linked to a negative mind-set which may lead to higher levels of frustration or despondency.</li> <li>- For some individuals, the concepts of religion, spirituality, and culture are inextricably connected.</li> <li>- More intra- and interpsychological longitudinal studies are suggested so that concepts of spirituality, culture, and mental health can be better understood.</li> </ul>	
Tokpah and Middleton (2013)	Psychiatric Nurses' Understanding of the Spiritual Dimension of Holistic Psychiatric Nursing Practice in South Africa: A Phenomenological Study
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Spirituality is an essential component of holistic nursing care.</li> <li>- The dimension of spirituality should be attended to in a nurse's treatment of patients.</li> <li>- Nurses should include an assessment of their patients' religious and spiritual beliefs, and a consideration of how this can be facilitated in treatment must be included in their treatment plans.</li> <li>- Spiritual and religious counsellors must be viewed by nurses as being valuable constituents in multi-disciplinary teams.</li> <li>- Education and training should be provided to nurses during their training so that they can understand and respect the role of spirituality for their patients.</li> <li>- More research is suggested in establishing guidelines for holistic care that includes spirituality.</li> </ul>	
Mthembu, Roman, and Wegner (2016)	Teaching Spirituality and Spiritual Care in Health Sciences Education: A Systematic Review
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Health Sciences departments should focus on developing healthcare professionals who have knowledge and skill in the area of spirituality so that patient care and treatment can be optimal.</li> </ul>	

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<ul style="list-style-type: none"> <li>- When teaching about spirituality in the Health Sciences, the following factors were found to be the most integral to achieving teaching outcomes: cultural beliefs, diversity and social justice, ethics, spiritual competence, a person-centred approach, and evidence-based practice.</li> <li>- Students should be taught to define terms such as spiritual well-being, and religion. Students should also be exposed to theories of spiritual and religious development.</li> <li>- Ethical practice should be paramount to the incorporation of spirituality.</li> <li>- Students need to be equipped in spiritual competencies such as taking a spiritual history or referring to spiritual workers.</li> </ul>	
Jacobs and Van Niekerk (2017)	The role of Spirituality as a Coping Mechanism for South African Traffic Officers
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- The role of spirituality in the traffic officers' lives was partly informed by their upbringing.</li> <li>- Spirituality and dependence on a higher power was associated with higher levels of coping, especially in depending on that higher power for protection within a highly dangerous work environment.</li> <li>- Spirituality provided the officers with a framework of morality and ethics.</li> <li>- Spirituality was an integral force in structuring the officers' worldviews, giving meaning to their lives, and assisting them in seeing their vocation as a calling.</li> </ul>	
Selebalo-Bereng and Patel (2018)	Reasons for Abortion: Religion, Religiosity/Spirituality and Attitudes of Male Secondary School Youth in South Africa
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Men are increasingly becoming more expressive about their own views on abortion and how this relates to the rights of the mother, the rights of the foetus and the rights of the father.</li> <li>- In South Africa, the divergent religious views on abortion have an impact on how it is perceived and how it is approached.</li> </ul>	

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<ul style="list-style-type: none"> <li>- The authors suggest that addressing stigmatisation about abortion that is founded within religious beliefs may be necessary in a South African context.</li> <li>- The authors recommend that interventions at secondary school level be introduced in which discussions, debates, and education around differing religious as well as gender discrimination issues can be facilitated in relation to reproductive topics such as abortion.</li> </ul>	
Nkomo, Herbst and Du Plessis (2018)	The Spiritual Journeys of a Group of Healthcare Professionals at a South African Provincial Hospital
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- Not only is the understanding of spirituality essential in the understanding of clients or patients, but it should also be fostered in professionals within healthcare settings in South Africa.</li> <li>- Spirituality can act as a source of coping for healthcare professionals.</li> <li>- In-service training can equip healthcare practitioners in gaining skills for the sensitive integration of socio-cultural and spiritual beliefs.</li> </ul>	
Du Plessis, Froneman, Shopo, Tau and Sojane (2018)	Promoting Caring Presence in Nursing: Initial Findings
<p>Main Findings:</p> <ul style="list-style-type: none"> <li>- The authors propose an acronym based model, DREAM, for the establishment of caring presence in the profession of nursing for South Africa.</li> <li>- The acronym stands for the following dimensions:  D – Dedication  R – Respect, Relationship  E – Education, Environment  A – Art of Nursing, Attitude, Advocacy  M – Motivation</li> <li>- The integration of religion and spirituality as a means of respecting patient and practitioner rights is inherent in the DREAM model.</li> <li>- The authors recommend that this model be used to establish protocols for establishing the practice of caring presence.</li> </ul>	

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The sample of South African based publications included in the table above is illustrative of the fact that religion, spirituality, society, and mental health is becoming an area in which research interest is increasing. As Van der Merwe (2010) states, psychological science has now incorporated the study of religion as an important dimension of human experience, which implies the necessity to understand the influence that religion has on both an individual, and a collective basis within the South African context. There is a pluralism of worldviews within this country, with census statistics showing the dominant worldviews of South African citizens are those of the Christian or African traditions (Van der Merwe, 2010). Within these Christian and African worldviews is a wide diversity of beliefs, which makes for an array of culturally, contextually, and socially informed worldviews. One cannot, therefore, generalise that a Christian or African worldview is uniform and homogenous in nature. Regardless, a worldview remains an essential and inherent framework through which a person understands themselves and others, thereby attributing meaning to their lives. Religion and spirituality often form a crucial component of one's worldview and underlie assumptions made about life (Van der Merwe, 2010). To negate a person's transcendent connectedness to self or other, in whatever form that may take, would be to negate the essence of that person. Van der Merwe (2010) states, therefore, that a crucial task of any health or pastoral professional in South Africa is to come to a comprehensive understanding and acknowledgement of the spirituality of people, so that they can attend to the person holistically.

For the South African context, however, the cultural dimension of an "African" understanding of health and sickness must be recognised as an inherently religious and spiritual one that influences the formation of a specific worldview (De la Porte, 2016). Because South Africa is not a homogenous nation, but is a diverse and multicultural one, it cannot be assumed that the term "African" beliefs is representative of the manner in which all South Africans form their worldviews (Louw, 2008 as cited in De la Porte, 2016). When considering idiosyncratically "African" interpretations of health and illness, some of the following factors must be at the forefront of that consideration:

- Religion and spirituality play a central role in the lives of the vast majority of South Africans (Schoeman, 2017);
- Manala (2005) proposes an Afro-Christian model of addressing sickness or illness in South Africa that is founded on both biblical and African-cultural values. The latter includes the centrality of Ubuntu principles such as community, mutuality, self-sacrifice for the sake of the other, and a belief in God's healing power;

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- African spirituality is experienced and expressed in an inclusive and communal context that includes reverence for ancestors which promotes unity and continuity in life (De la Porte, 2016);
- Within the context of a post-colonial and post-apartheid South Africa, the role of religion and spirituality must be acknowledged and given due consideration (Schoeman, 2017);
- Religion and spirituality are components of multicultural therapy and therefore professionals in the healthcare sector should gain information about a client or patient's spiritual and cultural beliefs so that the interface thereof can be discussed (Naidu & Ramlall, 2016);
- De la Porte (2016, p. 1) refers to the term "contextuality" to bring attention to the fact that behaviour is embedded in the context within which it occurs, and is thus affected by people's attitudes, values, customs and rituals. In this way, religion and spirituality become part of contextuality and must be incorporated in forming an understanding of behaviour;
- In their work on trauma, specifically within the South African context, Herbst and Reitsma (2015) make reference to the fact that people frequently make sense of trauma and suffering through religious and spiritual narratives. These narratives have to be evaluated and incorporated in the course of treating the trauma;
- Church organisations and religious workers may have a specifically valuable role in the healthcare sector of South Africa in providing healthcare teams with insight into how health and wellness is conceptualised within religious, cultural and spiritual realms (Magezi, 2012);
- The concept of healing should be one that is holistic and considers the myriad of socio-political factors that shape South Africa's past and present (Magezi, 2008);
- The role of the church as an institution of support should not be undermined and should be seen as a resource for healing in South African communities (Magezi, 2008).

These above points illustrate the requirement for the South African context to be conceptualised in a comprehensive and holistic manner, with an emphasis on the intersection of cultural and religious or spiritual beliefs.

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This is further supported by findings regarding The Social South African Attitudes 2<sup>nd</sup> Report (Rule & Mncwango, 2010) which shows the differentiation of churches that people are affiliated with when identifying themselves as Christians in the 2001 consensus. The majority of citizens, 32.45%, were affiliated with African Independent churches, with the second largest majority, 24.98%, being affiliated with Mainline Protestant churches. Considering that African Independent churches were shown to be the most represented within the South African population, it is necessary to evaluate the interface between mainstream Christianity and traditional or cultural beliefs. As previously mentioned, the largest religious affiliation in South Africa, after Christianity, is the traditional/tribal/ancestral grouping, which implies that an understanding of the South African context would require an appreciation for an African Christianity, which may perhaps differ from an internationally informed definition of Christianity (Schoeman, 2017).

Within the South African context, special attention must be given to the integration of religion and spirituality due to the ethical and legal frameworks in which practitioners are expected to comply. A recent textbook publication by Naidu and Ramlall (2016) recognises the imperativeness of integrating religion and spirituality in mental healthcare in South African society. To this end, their publication includes a chapter titled “From psyche to soul: psychotherapy and spirituality”. This chapter reviews both theoretical and practical implications for the integration of religion and spirituality into healthcare domains, particularly in the arena of mental health.

Ramlall and Naidu (2016) make reference to the ASERVIC competencies as a means of integrating religious and spiritual beliefs into practice, and considering the role of Spiritual Intelligence in clients. The ASERVIC competencies consist of a set of 9 competencies that should be met by counselling professionals who are working with clients from divergent religious and spiritual traditions. These competencies were agreed upon and developed by counsellors and counselling educators in 1995 at a Summit on “Spirituality Addressing Spiritual and Religious Issues in Counselling (ASERVIC)”. These guidelines were developed as an adjunct to the American Counsellors Association code of ethics and were constituted with the aim to “recognise diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (The Spiritual Competencies, ACA, 2009, p. 1). There was an endorsement of these competencies by the American Counselling Association Governing Council and in 2008 the competencies were revised at Summit II of ASERVIC. The revised competencies underwent factor analysis,

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and a six-factor solution was endorsed in May 2009 (Ramlall & Naidu, 2016, p. 378). Ramlall and Naidu (2016) provide an overview of the ASERVIC competencies in their entirety, but the most important tenets of the guidelines are:

- Culture and Worldview: respecting cultural and worldview differences, having a knowledge of what these systems entail;
- Counsellor Self-Awareness: counsellor reflexivity and self-evaluation about own religious and spiritual views, the use of referral systems when required;
- Communication: counsellor responds to the client with understanding and sensitivity, counsellor also includes spiritual and religious concepts that are relevant and acceptable to the client;
- Assessment: the client's religious and spiritual perspectives must be reviewed in the assessment and intake phases of treatment;
- Diagnosis and Treatment: counsellor must consider the way that religious and spiritual beliefs might enhance well-being, or conversely may exacerbate symptoms. Goals must be set with the clients that are conducive to their religious and spiritual beliefs, and the counsellor should modify therapeutic techniques so that therapy is inclusive of religious and spiritual components.

The ASERVIC guidelines are not the only ones that have been reported to be applicable to the South African context. The South African Society of Psychiatrists (SASOP) has been overt in its approach to the integration of religion, spirituality, culture, and mental health. SASOP published a position statement that stated the following (Janse van Rensburg, 2014, p. 134):

### SASOP position statement 9 on Culture, Mental Health and Psychiatry

Culture, religion and spirituality should be considered in the current approach to the local practice and training of specialist psychiatrists. This should, however, be performed within the professional and ethical scope of the discipline, and all faith traditions and belief systems in the heterogeneous SA society should be respected and regarded equally. In the public sector domain, no preference for one particular tradition should be given over another, as a result of a practitioner or a dominant group being from the one tradition or the other. Building relationships of mutual trust and understanding will require

training and health education initiatives aimed at psychiatric practitioners, their patients, carers and students, and cultural and religious practitioners whom patients and their carers may choose to consult. The protection of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, however, needs to be ensured, and all forms of abuse in this context, or neglect and delay with regard to appropriate psychiatric care should be identified and prevented.

As can be seen from this position statement, there is reference to the fact that South Africa is heterogeneous in its faith and cultural traditions. The underlying framework of this position statement is one that reflects the constitutional directive to protect citizens from discrimination or prejudice on the basis of their religious or spiritual beliefs. Furthermore, there is mention of the requirement for education and training initiatives to be developed for an inclusive approach to be possible. Considering that the disciplines of Psychiatry and Psychology often see patients or clients who present with similar symptoms, the field of Psychology should take this position statement as being equally relevant to their practice. There is no position statement regarding religion and spirituality available from the professional bodies for Psychology in South Africa, which implies that this is an area where further guidelines for competent psychological practice is absolutely imperative, and conspicuous in its absence.

In 2014, Janse van Rensburg (2014) published guidelines for the integration of spirituality into Psychiatric practice, which were to be understood within the context of the position statement above. With there being an overlap between culture, religion, and spirituality, there is a necessity for the disciplines of Psychiatry and Psychology to consider the extent to which these domains must be integrated into professional practice. This includes a consideration of training, and the content of curricula at both undergraduate and postgraduate levels. The content of the curricula would need to include basic spiritual and cultural competences, as well as ethical guidelines for acceptable practice. With research on culture, religion, and psychiatry being constantly underway, greater insight into the influence of worldviews on treatment and patient compliance must be sought. Mental health policy and approaches to the training of professionals would then be augmented on the basis of these findings. Janse van Rensburg (2014) does, however, make a distinction between religion and

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spirituality when it comes to the integration thereof into professional practice. He states that religion and spirituality need to be “separated” and “distinguished” from one another “when it comes to the practice of medicine, psychiatry and psychotherapy” (Janse van Rensburg, 2014, p. 135). Janse van Rensburg (2014, p. 135) quotes Frankl (1986) as stating that “the goal of psychotherapy is to heal the soul, to make it healthy; the aim of religion is something entirely different, to save the soul”. The implication, therefore, is that religion’s emphasis and purpose is a separate one to spirituality, and so the two should not be merged. Although the separation of religion and spirituality is encouraged, the outworking of this separation in clinical practice is not as clearly delineated.

With the requirement of mental health practice to be adaptable across cultural, religious and spiritual diversities, Janse van Rensburg (2014, p. 136), states that the following practice guidelines have been established for the field of Psychiatry in South Africa:

- Integrating defined spirituality in clinical care and in-service provision and use, by practitioners and patients, in their own lives and in terms of their professional therapeutic relationship;
- Integrating defined spirituality in the training of local undergraduate and postgraduate students in Psychiatry;
- Ethical integration of defined spirituality within the professional scope of practice;
- Appropriate referral of patients and collaboration between psychiatrists and spiritual/religious advisors.

Considering that there are no other published guidelines for the integration of spirituality into professional mental health practice, these guidelines provide a comprehensive framework for the centrality of considering the role that spirituality plays in both patient and professional. Furthermore, the guidelines are relevant to mental health professions in their entirety, and provide an extremely useful point of departure for other professionals. Janse van Rensburg (2014) extrapolates on these guidelines by means of providing a comprehensive explanation of each one of them. Some of the most applicable guidelines for the purposes of this PhD study are as follows:

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- Taking a spiritual and religious history when assessing a patient, and ascertaining the spiritual needs that the patient may have;
- The inclusion of spirituality into health-care programmes, and various fields within psychiatry (child, adolescent or geriatric psychiatry);
- Allowing for health care structures and environments to be accommodating of a patient's spiritual or religious preferences (e.g. dietary needs);
- Integrating defined spirituality in the training of local undergraduate and postgraduate students in psychiatry;
- Knowing what the role of spirituality and religion is in psychopathology (education at postgraduate level);
- Understanding the role that culture, religion and spirituality play within various communities;
- Gaining insight into how various traditions view health, illness, and mental health;
- Incorporating a holistic approach to patient care through the use of the biopsychosocial-spiritual model;
- Retaining a focus on the accurate diagnosis and treatment of patients;
- Referring to and collaborating with spiritual leaders when this is requested or indicated;
- Working within a multidisciplinary team in which holistic perspectives towards health, illness and wellness can be evaluated;
- Maintaining and achieving necessary competency levels in providing holistic and integrative treatment.

As mentioned, these guidelines are clearly applicable to healthcare systems in general, and not just within the discipline of Psychiatry.

The requirement for healthcare professionals to refer clients or patients to spiritual and religious leaders is an essential one, because it reflects the ethical and legal obligation for healthcare professionals to act within their defined scopes of practice. As will be shown in the findings and the discussion chapters of this PhD thesis, both the pastors and the psychologists who participated in the study mentioned the issue of referral across disciplines. When considering the importance of an integrative approach to treatment, and the requirement to refer patients when indicated, Janse van Rensburg, Poggenpoel, Szabo, and Myburgh (2014) posit

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that a biopsychosocial-spiritual approach to patient care is the most applicable approach for a South African context. This model of treatment should allow for the integration of spiritual and religious beliefs, as well as the inclusion of spiritual or religious advisers in multidisciplinary team treatments. In order for inclusion to be facilitated, Janse van Rensburg (2014) conducted a study to determine the experiences and views of psychiatrists on the role of spirituality in specialist psychiatry practice and training, where the data of that study gave rise to the category of “referral and collaboration between psychiatrists and spiritual professionals” being an essential one (Janse van Rensburg et al., 2014, p. 42). Within this category, three subcategories for effective referral and collaboration were identified, namely:

- Facilitating appropriate referral and intervention for individual users;
- Information sharing and mutual awareness between disciplines;
- Addressing stigmatisation of users with psychiatric conditions.

From the above subcategories, it can be implied that stigmatisation is an area where much change is required. The presence of stigmatisation is a phenomenon that Patel and Shikongo (2006) report on in their South African based study of the understanding of religion and spirituality in a group of Muslim postgraduate psychology students.

Patel and Shikongo (2006) undertook this study because research in the subject of R/S is increasing, and the need to include a focus on R/S in training programmes for psychology was becoming more pronounced. Patel and Shikongo (2006) state that the necessity for R/S to be considered by the field of Psychology within the South African context is even more imperative, because of the multiculturalism of the nation and the consequential probability that religious and spiritual dilemmas may influence psychological symptoms. However, in order for clinicians to accurately identify and treat psychological disorders, they must possess the training and skills that are required to determine the presence of R/S dilemmas.

In Patel and Shikongo’s (2006) study, they interviewed Muslim psychology students in the second year of their Master’s degree, about their definitions of spirituality, how they perceived spirituality’s role in therapy, and their experiences as Muslims in their training as psychology students. The results were then analysed by use of a framework approach whereby main themes of the research were found.

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When it came to the definition and understanding of spirituality, the main theme that emerged was the fact that spirituality is the central component of who a person is, and cannot be separated from one's general functioning. Furthermore, all the students felt that spirituality was imperative in gaining a holistic conceptualisation of their clients' psychological status. This extended to knowing the client's spiritual background, which would be important in understanding the presenting problem. The students also found spirituality to be a central component of people's lives, because people sometimes attribute the occurrence of life events to spiritual causes, or see a link between psychological symptoms and the consequences of neglecting one's spiritual growth.

On the topic of training, the students in this study (Patel & Shikongo, 2006) thought that there was a disparity between the salience of religion and spirituality to the proportion of training allocated to this subject area. This led to feelings of frustration, conflict, uncertainty and inadequacy for the students. The students in this study felt as if the field of Psychology had distanced itself from R/S, because these disciplines are not seen as being scientific in origin, and therefore not the realm of psychological science. This was reflective in the fact that their professional training contained little to no emphasis on the religious and spiritual dimensions of clients, or the interface of R/S and psychology. With little to no training in these themes, students reported feeling high levels of incompetence and helplessness when working with clients that presented with any form of religious or spiritual material. Two of the participants stated the following regarding their incompetence to deal with religious issues as cited in Patel and Shikongo (2006, p. 105):

We are ignoring a very important dimension of treatment that makes our therapy incomplete.....it makes me question our actual efficiency at the end of the day.

If we don't approach a human being from a holistic point of view, we only have the job half done.

Part of the students' frustration also came from the fact that they felt biased against within their training programmes due to their religious orientations. Some of the participants in this study (Patel & Shikongo, 2006) even attempted to disguise their religious affiliations in the process of Masters selection, in the hope that they would appear to be neutral, "fit enough", and therefore, not too "conservative" or, too "rigid" (Patel & Shikongo, 2006, p. 104). When

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some of the students were involved in assessment type activities with the supervisors, they felt as if they were discriminated against by their supervisors if they included religion and spirituality in the process with their client, which often led them to omit mentioning the spiritual dimensions of therapeutic processes.

These decisions to appear neutral for the purpose of selection, or to withhold information about the spiritual dimensions of therapeutic processes made the students feel as if they had been forced to compromise on their “religious integrity” (Patel & Shikongo, 2006, p. 104), which evoked much emotional distress for the students. In this way, these authors mention that although Western models of thought may view religion as a subsystem of culture, for many religious people, religion is not seen as a subsystem, but rather as the essence of their worldview. Therefore, to separate religion from “who the students are” in an existential sense gives rise to much inner turmoil.

Patel and Shikongo (2006) state that there are some implications that can be drawn from the students’ experiences with the faculty of their training programmes. Firstly, when you are seen to be religious, there is an assumption made that you will be conservative and rigid in the approach to treatment. Secondly, it appears as if the faculty personnel became concerned that students would impose their own values on their clients instead of treating them in a more objective or tolerant manner. These are perhaps misconceptions that could have been dialogued if opportunity had been created for discussions that addressed issues relating to spirituality and religion. However, Patel and Shikongo’s (2006) study showed that there was an exclusion of training regarding spirituality from these students’ training programmes, and so these dimensions were not freely explored. All the students in this study, however, felt that it was imperative to include instruction and guidance about how to navigate issues of spirituality and religion in the context of psychotherapy with clients. The students felt as if they were treating their clients in an unethical way by failing to follow a biopsychosocial-spiritual approach to therapy, and thus being inept in integrating a spiritual aspect to the assessment, diagnosis and treatment of patients within a South African context. Much of this resistance to the expression, integration and understanding of religion or spirituality was formed within the context of underlying stigmatisations. This study, therefore, brings attention to the fact that stigmatisations of religion and spirituality exist within the South African context, and that these stigmatisations are an obstacle to effective and respectful integration.

Just because stigmatisation exists, however, does not automatically imply that there will be an immovable resistance to an integrative healthcare approach. To gain more information about the use of an integrative approach, Brown, Elkonin and Naicker (2013) conducted a South African based study in which they interviewed psychologists to determine the extent to which psychologists would use religion and spirituality in the context of psychotherapy. The aim of the study was to explore the factors that enable and prevent the use of religion and spirituality in psychotherapy. The rationale for this study (Brown et al. 2013) stemmed from the fact that Psychology is traditionally a field that does not encourage the integration of religion and spirituality within the psychotherapeutic process, but is now being challenged to revisit those ways of thinking. Two papers were published from this study, one in 2013 (Brown et al. 2013) and one in 2014 (Elkonin, Brown & Naicker, 2014), both of which will be discussed in this section.

Brown et al. (2013), similarly to Janse van Rensburg et al. (2014), reflect on the fact that the biopsychosocial-spiritual model of healthcare is seen as a model that allows for both the holistic understanding and holistic treatment of a patient, and is therefore a more existentially appropriate model of healthcare than the traditional biopsychosocial one. However, the practicality around an integration of religious and spiritual aspects into a psychotherapeutic process becomes more complex. For the purposes of this study, Brown et al. (2013) explored psychologists' understandings of the concepts of religion and spirituality, and their perceptions of how these concepts are used within the context of psychotherapy. The psychologists were placed in focus groups and were asked the following five open-ended questions, the answers to these questions were analysed using content analysis where themes and subthemes were determined:

- *How do you understand the concepts of religion and spirituality?*
- *What are your perceptions about using religion and spirituality in therapy?*
- *Discuss whether you would use religion and/or spirituality in therapy. If so, how? If not, why not?*
- *What makes it possible for you to engage with clients on this level?*
- *What are the barriers to engaging with clients on this level?*

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In Brown et al. (2013), the themes relating to the extent to which participants would be willing to use spirituality and religion within the psychotherapeutic context revealed a difference between implicit and explicit forms of integration. Some participants felt comfortable in overt forms of religious activity for example, prayer for the client, and other participants felt more comfortable with implicit activity for example, praying in private for the client before or after a session. However, the majority of the participants reported that they would prefer not to engage with an overt display of religious or spiritual activity, although they would be willing to have a discussion about those themes. As Tan (1996) describes, integration takes place on a continuum of implicit and covert through to explicit and overt. Practitioners fall somewhere along that continuum in their comfort with integration. Some of the participants in this study (Brown et al. 2013) voiced their concern with explicit integration, because they were not sure what their clients would do with that religious material/information, and therefore had very little control over whether it would be used to worsen their pathology.

Regardless of where on the implicit or explicit continuum the participants fell, they remained steadfast in their perception that the clients' needs should determine the course of therapy, and that their need may, in fact, require the discussion of religion and spirituality, which should be met with acceptance from the psychologist. As Patel and Shikongo's (2006) study revealed, participants stated that it was actually detrimental and neglectful of psychologists to ignore issues of spirituality if this is what the client brings into the psychotherapeutic process. Similarly to the results discussed in Section One, the participants in the study by Brown et al. (2013) stated that the presence of their own spiritual beliefs or commitments made it easier to engage in discussions of a spiritual nature with clients, which therefore lessened the risk of clients feeling as if their spiritual or religious needs had been neglected. Participants reported that the theoretical approach from which they had been trained played a role in the comfort that they felt with integrating religion and spirituality. Participants who had been trained from a person-centred approach, a holistic approach, or from a positive psychology approach found that these approaches better facilitated discussions around religion and spirituality.

When it came to the barriers that the participants experienced in discussing religion and spirituality with clients, one of the main barriers that the participants mentioned was their concern about ethics. One of the participants said the following:

We are scared of the ethics. There's a certain boundary, and it's an ethical boundary that stops you from going forward... (Brown et al., 2013, p. 1140).

Participants were concerned about acting outside of their scope of practice due to the fact that the Health Professions Act (1974), as cited by Brown et al. (2013), is clear that psychologists should not assume a professional role when other factors (including legal, scientific, relational) could impair their objectivity, competence or efficacy as a psychologist. Although the participants were aware of this statute, and their limitations in competency, they judged their limitations in competency to be a barrier to their comfort in engaging with their clients about religious and spiritual issues. That being said, the participants acknowledged that their primary role remains that of a psychologist, and that the boundary into other professional roles for example, religious instructor, should not be crossed.

“Conflicting beliefs” was a theme that was raised by the participants, because psychologists may feel comfortable with their own belief systems, but may then be uncomfortable when it comes to beliefs from dissimilar religious or faith backgrounds. Not only are psychologists faced with dissimilar religious or faith backgrounds, but they are also sometimes faced with clients who have moral systems that differ vastly from their own. A clash in value or moral systems was experienced as more problematic for some participants than a dissimilar religious or faith background. Differing religious, spiritual, or moral values, however, remain a barrier to psychologists' ease in discussing these factors within psychotherapy.

The other instances where the participants thought that religion acted as a barrier to psychotherapy were the times in which clients became passive in making decisions, used religion as a defence, used religion as a justification for their behaviour, or interpreted elements of their religion in a self-serving manner.

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As already reviewed earlier in this section, the South African Constitution and the Bill of Rights are integral in determining the respectful treatment of South African citizens. In their second publication, these authors (Elkonin et al. 2014) cite this legislation as a foundation upon which all individuals' rights to freedom of religion, and freedom to express that religion, must be respected. These cannot be precluded from psychotherapy as the argument then becomes that the psychologist or practitioner may, in essence, be acting unethically and unconstitutionally by not addressing the spiritual or religious aspects of the client's reality. However, if the psychologists or practitioners feel untrained or incompetent in addressing matters that interface with religion, spirituality and mental health, then this will inhibit their willingness to engage in such discussions.

The results of the first two questions were reported in the Elkonin et al. (2014) publication and will therefore be discussed in this section. Considering the fact that there is not much research available on religion, spirituality and psychology within a South African context, and considering that this study (Elkonin et al. 2014) is the only published study to document psychologists' perceptions to some of these themes, I will review the themes and subthemes reported in Elkonin et al.'s (2014) study with some detail. Concerning the participants' understanding of the concepts of religion and spirituality, it was clear that there was some difficulty and vagueness experienced in attempting to find an all-encompassing definition. Religion was, however, viewed more negatively whereas spirituality was seen in a more favourable light. Religion was associated with rigidity, severity, and legality, whereas spirituality was seen to be less structure bound. Furthermore, religion was seen by the participants as being a prescriptive, externally based phenomenon with spirituality being an internal and personal, choice-centred, experience. With the prescriptive nature of religion comes the perception that there is an expectation to be involved in institutionalised activities such as church attendance, whereas spirituality can be lived out in one's state of mind, which is more flexible.

In this study by Elkonin et al. (2014), the participants perceived the concepts of religion and spirituality to be linked in two ways, namely "spirituality was perceived as the internalisation of religion, and it was also perceived as the expression of religion" (Elkonin et al., 2014, p. 125). Therefore, the participants in this study implied that spirituality can be the result of an internalised religion, and that spirituality can be the expression of that internalised religion. The authors (Elkonin et al., 2014) state that although literature concurs that people experience and express religion and spirituality in individualistic ways, there is little reference

to the fact that spirituality can be the expression of religion, and that the two domains can co-exist with ease. In this way, their study added new knowledge and findings to the growing research on how people conceptualise religion and spirituality.

The second question posed to the participants was what their perceptions were about using religion and spirituality in therapy. One of the main themes that arose was the psychologists' opinions that it is imperative to be aware of their clients' needs when it comes to religion and spirituality. This includes allowing a space in which clients feel comfortable to discuss those issues, at their own pace. The participants did not feel that psychologists should be the ones to initiate such discussions though, out of concern that they would inadvertently impose their own values onto their clients. One of the participants in this study (Elkonin et al. 2014) stated that the therapeutic space should be one that is kept neutral. However, the authors of this particular study reflected that the concept of value-neutral therapy is one that has been under contention for quite some time now, that value-neutral therapy is unattainable, and should rather be replaced with an open-mindedness (Kahle & Robbins, 2004). One of the factors that seemed to shape the participants' perceptions about using religion and spirituality in psychotherapy was the requirement to be cognisant of the times in which their scope of practice was being challenged by the content of the psychotherapeutic process. In times where they felt as if their levels of competency precluded them from being effective concerning a religious or spiritual tension that the client was facing, the participants reflected that they would have to refer to pastors or spiritual leaders. However, the nature and process of that referral was not as clearly defined.

The discussion of competency and referral gave rise to the related discussion of training amongst these participants. The participants recognised an interesting fact in that their training around religion and spirituality had had a direct influence on how they felt about the integration of these factors into the psychotherapeutic context, and the influence this had on a client. Some of the participants in this study stated that they had been told during their training that religion and spirituality is a "sensitive issue" and were told "not to bring it in", with another participant reporting that religion and spirituality was something that he/she had received no training in, but yet "we find that it's such a big part of therapy" (Elkonin et al. 2014, p. 129). This finding is similar to the one reported by Patel and Shikongo (2006) in which they reported that the participants in their study mentioned that training in the area of religion and spirituality had been omitted and neglected from their professional education.

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Nonetheless, the participants acknowledged that religion and spirituality often remains a supportive means of coping both for clients and for psychologists, and that psychologists should be open to discussing these themes with clients who deem them to be existentially significant. Even if the themes of religion and spirituality are not discussed with the clients, some participants noted that they often remain central to the psychologist's own worldview, and mechanisms of coping. Some of the participants reflected on this by saying things such as:

.....I felt so overwhelmed about their problems.....and I was just like, ok, for me, like God please guide me in the right direction (Elkonin et al. 2014, p. 129)

...I'm trained to do the work but without this supreme power, I wouldn't know where I'd be (Elkonin et al. 2014, p. 130)

Regardless of the clients' cultural or religious beliefs, the participants still reported that they would need to accept and respect those beliefs. According to the participants (Elkonin et al., 2014), it is the psychologist's duty to be curious about the client's story by exploring and understanding his/her world, and if religion or spirituality factors into this process, then it should be explored with equal ease. Considering the fact that South Africa is a multicultural society, there should be no illusions about the fact that there is a plethora of possible worldviews and associated meanings that people hold as salient. This study showed that one's spirituality and religion is an inherent component of one's cultural identity and should therefore be treated with as much respect as the other facets of one's cultural identity. It also demonstrated the nature of how religion and spirituality might be perceived and dealt with within the field of Psychology, indicating the areas where transformation should proceed.

Padayachee and Laher (2014) further the South African based research into the suppositions reported in Elkonin et al. (2014) by reflecting on the fact that mental illness cannot be accurately interpreted without doing so within the context of cultural norms. This is because mental illness is expressed and understood specific to the culture within which it occurs; the way that health or illness is perceived within cultures will therefore determine the way that the illness has to be treated. As stated previously, South Africa is a multicultural and multireligious nation which potentiates the necessity for a plurality of understandings when it comes to mental health. Padayachee and Laher (2014) note that a generalised Western approach to mental health does not capture the nuances of other cultural systems of belief. Within the Hindu faith, beliefs

about physical and spiritual health are intricately interwoven with those of mental health. Therefore, according to this tradition, a spiritual illness can give rise to a mental illness, the two may exist independently of one another, or one can be misinterpreted as being the other (Padayachee & Laher, 2014). Although Hindu individuals seek professional treatment for psychological distress, their cultural and faith-based beliefs may still present in the context of psychotherapy and would be alternative to those held by more Western paradigms.

The study conducted by these authors (Padayachee & Laher, 2014) explored Hindu psychologists' perceptions of mental illness, and the influence that their own religious beliefs have on these perceptions. Semi-structured interviews were conducted with six Hindu psychologists and thematic analysis was used to analyse the data.

From the data collected, it was clear that the psychologists interviewed acknowledged the importance of religion in how they understand and conceptualise constructs of mental illness and health, as well as in their approaches to treatment. The Hindu psychologists interviewed stated that they would be open to referring patients to spiritual workers in cases where it was necessary, as long as therapeutic processes were not subsumed by spiritual ones, and that a collaboration between the two processes would be optimally beneficial for patients. The concept of cultural competence was emphasised by the participants in this study by mentioning that clinicians should possess knowledge of the nuanced dynamics that are idiosyncratic to Hindu communities. One of the participants made the following statement:

I truly believe that so many of the actual problems that Hindus face fall through the cracks when they go to therapy because a non-Indian psychologist won't understand where this person is coming from and how their family relationships, for example, influence their lives (Padayachee & Laher, 2014, p.12)

Psychology and Psychiatry are not the only healthcare fields in South Africa to be considering the role of religion and spirituality. The fields of medicine, nursing, social work and occupational therapy all include researchers who are currently conducting PhD studies, completing PhD studies, or publishing in this subject area. Bhagwan (2013) published a review of South African academic social workers and their perspectives on the inclusion of spirituality in social work practice. Although the participants showed high levels of spirituality and religiosity in their personal and professional spheres, this had not been reflected in the inclusion of education around religion and spirituality within social work undergraduate and

postgraduate education/training. The author (Bhagwan, 2013) proposed that religion and spirituality should be included in training for social work programmes and encouraged more research within this sphere to take place for the healthcare professions in South Africa. Mthembu, Wegner and Roman (2017) have noted the requirement for occupational therapy students and educators to become acutely aware of the role of spirituality and religion within themselves, within the training programmes, and most importantly; within the communities that they are involved with. Botes and Botha (2018) studied the field of social work in South Africa and state that in order for social workers to meet the mandate of providing whole-person care, the aspect of spirituality cannot be ignored or undermined. They state that the dearth of research-based knowledge for an understanding and integration of spirituality in whole-person care has an adverse impact on the provision of effective healthcare within the South African context. Therefore Botes and Botha (2018) describe PhD research that is underway in order to establish guidelines for the ethical integration of spirituality in healthcare contexts, as well as strengthening inter and intra-disciplinary communication to bolster multidisciplinary cooperation. Meyer (2018) has similarly produced research from her perspective of being a medical practitioner in which she reiterates the indispensability for a model of healthcare that incorporates both the professional's and the patient's spirituality. Meyer (2018) states that the multi-religious and multicultural milieu of South Africa requires professionals to be competent in inquiring about a patient's religious or spiritual beliefs so that these aspects can be incorporated into the ethical, holistic assessment and treatment of patients.

### **Section Six: Implications and Conclusions for the South African Context: The Problem**

#### **Statement**

This chapter has reviewed some of the historical and recent relational dynamics between religion, spirituality and mental health, giving rise to the introduction of the problem statement for this study. These relational dynamics have not remained static, and seem to be progressing to a position of mutual recognition. At present, there has been an increased openness on both the international and national landscape in understanding the interface of these disciplines so that holistic patient or client care can be championed. Within the South African context, the role of religion and spirituality cannot be ignored, and it cannot be undermined in its relevance to the mental health of its people. With a significant majority of South Africans reporting to be following some form of Christian faith tradition, the healthcare

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professions of this country ought to investigate what this means for culturally sensitive treatment. Not only should the efficacy of treatment be reviewed in the light of religious and spiritual factors, but the ethical treatment of patients and clients encompasses an appreciation of these factors. As demonstrated in South African legislation, religious and spirituality diversity is inherent in multiculturalism and must be respected. The sample of publications provided in Table 5 is evidence of the salience of religious and spiritual considerations for the South African population, and the interest of healthcare professions in this research area. Religion and spirituality have now been recognised as being essential to the competent and ethical practice of Psychiatry, and other fields, in South Africa, which has resulted in SASOP publishing guidelines for its inclusion in assessment, diagnosis and treatment. Not only has the field of Psychiatry created such guidelines, but nursing, social work and the field of Medicine have similarly reviewed ethical practice for religious and spiritual factors. Sadly, it seems as if the field of Psychology is lagging behind in not including similar overt guidelines within its ethical code of conduct. This will be reviewed in Chapter Six.

One of the main ways in which the field of Psychology should adapt in the light of such findings is through the training of psychologists in issues of religion, spirituality and mental health. Furthermore, guidelines for the integration of religion, spirituality and psychological practice are vital in establishing ethical treatment of clients or patients. On both international and national fronts, the scarcity of education and training in this subject area is immense and should clearly be addressed. South Africa's context is one in which historical and socio-political factors permeate through all strata of society, and the provision of healthcare, which makes this country's need for whole-person care a critical one. Research in the area of South African multiculturalism and how that intercepts with religion, spirituality and mental health is required so that a biopsychosocial-spiritual model can be appropriately tailored in response.

## **CHAPTER TWO**

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**Section Ten: Conclusion**

## **Introduction**

This chapter reviews the methodological processes that guided this study. The rationale for using qualitative research in Section One is followed by reflexive ontological considerations in Section Two, which includes an outline of the researcher's personal history. Congruent with methodology for the thematic analysis method of data analysis, ontological and epistemological tenets are reviewed so that researcher transparency is provided. Flowing from this ontological and epistemological contextualisation, the aims, objectives and research questions for this study are stated in Sections Three, Four and Five respectively. The research procedures for the pilot study (Phase One) and the main study (Phase Two), indicate the research process followed in collecting the data required to meet the aims and objectives for answering the research questions. In Section Eight, a comprehensive review of the data analysis phases followed in thematic analysis are discussed to ensure the provision of an audit trail for this study. Lastly, the ethical considerations in this study are acknowledged and discussed.

## **Section One: Qualitative Research Approach**

As a trained psychologist, I have had much exposure to the basic tenets of qualitative research in both undergraduate and graduate training. This training was directed at developing knowledge about the benefits of qualitative research when studying human phenomena. Therefore, when the problem statement and the research question were formulated, I was aware of the fact that qualitative research would most likely be the most appropriate stance to incorporate, in order to gain data in answering the research question. When reviewing literature on the qualitative research methodology, a number of resources were consulted to substantiate the rationale for using this methodology, especially for the purpose of gaining insight into participants' perceptions. Perceptions are not something that can be easily quantified, and if quantitative methodology was used, it would not provide for as rich an exploration of the perceptions as what is required for this study. A review of the rationale to use qualitative methodology, and the epistemological and ontological positions held by the researcher follow in the section below.

### **Rationale for Qualitative Methodology**

As Maracek (2003) discusses, the use of qualitative research has become more prolific in psychological research over time, and is especially valuable and necessary when conducting psychologically-informed research. This is because the qualitative approach allows for the study of psychological factors within the context of societal and cultural factors; it champions an understanding of the participants within their lived-world contexts; and it sees participants as reflexive meaning-making agents that bring meaning to their lived worlds (Maracek, 2003). Camic, Rhodes, and Yardley (2003) remind us that psychological qualitative research is imperative in gaining insight into the existential reality of participants, and that this existential reality is a valid source of information upon which knowledge can be generated. In addition, healthcare contexts often yield complex social dynamics that require further research by healthcare professionals. Vaismoradi, Turunen and Bondas (2013) recommend qualitative research in such contexts, because it allows for a comprehensive understanding of complex social dynamics, it places the views and opinions of the participants as paramount, and it allows for the reporting of findings that reflect the participants' narratives. When considering that the research question for this study was based within a health professional's framework, which required an understanding of experiences, perceptions and meaning afforded to the participants, it became evident that a qualitative approach to the research would be suitable.

Furthermore, to be able to answer the research question in a detailed way, it was fitting to use a research design that allowed for analysis of human experience to be at the fore-front. Neuman (2007) refers to the process of asking questions to produce knowledge about the social world around us as "social research" (Neuman, 2007, p. 2). This study is social research as described above, because it is essentially designed to review the social and internal experiences of people in society. Social research can take the form of qualitative or quantitative research, but for the purpose of this study, qualitative research was necessitated. According to Bryman (2001), the following epistemological and ontological positions are characteristic of qualitative research, and are indicative of the positions that I, as the researcher, held throughout the research process:

- An inductive view where theory is produced from research;
- A constructionist ontological position where meaning is created through human interaction and is not separate to the individuals that create that meaning; and

- An interpretivist epistemological position held by the researcher so that an understanding of phenomena can be interpreted by reviewing participants' experiences.

### **Constructionist Ontological Position**

The methodology suggested for this study included an inductive and constructionist ontological approach, because as the researcher, I was required to produce findings and knowledge directly from the data. The interviews were the main source of data, and my coding of those interviews took place as I reviewed the experiences of the participants. When conducting these interviews, the process inherently led to the co-creation of meaning through human interaction. In fact, this was evidenced by a few events that took place in the interviewing process.

One of the pastors heard my use of the word “psychological distress” in making reference to diagnoses that congregants may have. He asked me to repeat that phrase and then told me that he was going to begin to use “psychological distress” rather than “mental health problems”, because he could feel within himself that it was a less stigma-laden and distancing term. That moment in the interview allowed for a discussion to evolve where he could reflect on his own perceptions of mental illness and how he wanted to be able to communicate differently about this to his congregants. Another pastor asked me during the interview if I were Christian. When I answered that I was a Christian, he told me that he was relieved to hear that, because he would be able to “speak more freely” about his perceptions without fear of being judged. In two other interviews, the pastors told me at the end of the interviews that they had realised through our interaction that they held many misconceptions and were ignorant about much of my field. This encouraged them to ask me questions about how to move forward in a way that was beneficial for their congregations.

When interviewing the psychologists, one of them opened the interview by saying that she was afraid to be interviewed by me, because her faith position is Christianity, and she was not sure if this would be a “problem” for me and for the study. When I reminded her that her faith was not a stipulated selection criterion for participation and that I would not judge her religious beliefs, she was ready to proceed with the interview. Some of the psychologists made statements at the end of the interview for example, “you have forced me to think about things today....”, and “some of your questions were ones that I expected, but you caught me by

surprise with other questions, its good, it made me think...”. These few examples provide evidence for the fact that the interviewing process is one in which meaning is co-created and ameliorated through interaction. A quantitative approach would not have afforded me the opportunity to reflect on how the participants’ perceptions had shifted within the actual interviewing process. This was critical information for the purposes of this study, because it illustrated that perceptions, including those of the researcher, can shift within the process of the human interaction in the research itself.

When considering my ontological position, therefore, the process that unfolded within the research supported my ontological position of constructionism. According to Dilts and DeLozier (2000), an ontological position refers to how a person’s existence is experienced and given meaning, and is influenced by their beliefs, their values and their life circumstances. In this way, reality is interpreted through the filters that define one’s existential reality. Not only is this true for the participants, but it is equally true for my role as the researcher, because I too will interpret interactions, perceptions and meaning through my own ontological position.

Bryman (2001), therefore, considers an interpretivist or constructionist ontological position as one where there is an acknowledgment that knowledge is formed, changed, reformed and influenced by and through social interactions. This ontological position was one that seemed to emerge noticeably within the process of the research, because each interview provided a context in which knowledge was co-created through the experiences of both the researcher and the participant. Some interviews resulted in the amelioration of meaning and perception by virtue of the research process itself, which indicated the social constructionism of knowledge.

### **Ontological and Epistemological Considerations**

The phenomenon of the co-creation of knowledge during the research process is well explained by Whitely (2002, p. 34) in reviewing the purpose of qualitative research in which both an epistemological and ontological position have an impact on the process of research:

- The focus of research is on understanding the experience, interpretation of experience and meaning that people place on different spheres of their lives;

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- The researcher's experiences in the research context determine what is studied and the methods by which it is studied. These are modified throughout the research process depending on how the research develops;
- The researcher is inextricably part of the process of research and has an impact on the research. Therefore, it is both the experiences of the researcher and of the participants that become a valuable source of data; and
- The researcher searches for the similarities and differences within how individuals and groups of people give meaning or interpretation to their experiences.

As mentioned, this study focuses on experience and meaning, not only of the participants, but similarly for the researcher too, which is why commentary on such experiences has been included in this chapter. The methods used to conduct this study were adjusted as the research developed, and the development of the study was dependent on both researcher and participant factors. Qualitative research therefore allowed me as the researcher to focus on the notions of experience, meaning and interpretation when considering the perceptions of the participants. This provided rich data where I was able to consider the similarities and differences that were present for individuals throughout the data set. Through those similarities and differences, themes of meaning were determined in order to give expression to the participants' perceptions.

Crowe, Inder, and Porter (2015) stipulate the efficacy of qualitative research when considering contexts or subjects that are complex and/or poorly understood. The research question for this study was a complex one in that it reviews the perceptions of two individual sets of data (pastors and psychologists), and then looks for the relationships of meaning between the two sets of data. Not only is this a complex study, but it is also a study into an area that was poorly understood as reflected in Chapter One, and where no South African studies could be found that reviewed the perceptions of both psychologists and pastors towards mental health. A qualitative approach is therefore the most suitable approach to achieve these objectives. It is the most suitable approach to this study, because it has as its main focus, the following principles which were in accordance with those stipulated by Vaismoradi et al. (2013, p. 398):

- An acknowledgement and belief by the researcher that multiple realities exist, which links to a social constructionist or interpretivist ontological position;
- The incorporation of an approach to research that allows for an in-depth comprehension and appreciation of what is being studied;
- “A commitment to participants’ viewpoints”; and
- Undertaking research in a manner that is as undistruptive to the context as possible;
- Reporting the findings in a way that places the viewpoints and commentaries of the participants as the focal point.

This study was structured with the above principles in place. The study reviews multiple realities, seeks an in-depth understanding of meaning, is focused on the viewpoints of the participants, recognises the necessity to preserve the natural context, and reports the findings in a way that emphasises the voices of the participants. Therefore, by its very nature and design, this study is one that follows a qualitative approach.

### **Exploratory Research Design**

This study sought to explore a new topic and issue by asking the epistemological question of “what”, what is the meaning of this social phenomenon (Neuman, 2007). By asking “what”, the study was exploring perceptions in order to generate knowledge about a subject that had not yet been studied within the context of South Africa. The study was also used to describe the details of the perceptions, and the contexts in which those perceptions were formed. The subject of the study was well defined and the presentation of the data described that subject in an in-depth manner, which makes the study descriptive in nature. Therefore, both an exploratory and descriptive approach to the qualitative analysis was followed.

To demonstrate the validity and rigour that this study was founded on, a review of the trustworthiness, reflexivity and confirmability, credibility, transferability, and dependability will be provided in Section Nine in order to make clear the process and potential pitfalls of the research in this study. Furthermore, to establish the reflexivity that is critical to establishing my ontological position, I will provide a brief biographical account in order to make overt the underlying values, beliefs and existential reality that has informed my interpretation of the data.

## **Section Two: Reflexive Ontological Considerations**

The format of this chapter has been structured with a specific purpose in mind. With this study being a qualitative one, the requirement for the researcher to disclose personal information and possible biases, and to be as reflexive as possible, is critical to the integrity of the research itself (Marecek, 2003). Nowell, Norris, White, and Moules (2017) consider criteria for ensuring the trustworthiness and rigour of qualitative studies, and posit that reflexivity as one of the primary methods by which to achieve this. Although trustworthiness and rigour will be discussed in Section Nine, reflexivity is a process that adds to trustworthiness, and is inherent throughout a qualitative inquiry. Therefore, reflexivity must be defined at the start of this chapter so that the rationale for the structure of the chapter can be provided. Nowell et al. (2017, p. 3) define reflexivity as the “self-critical account of the research process, including their internal and external dialogue”, and an audit trail as “a trail (that) provides readers with evidence of the decisions and choices made by the researcher regarding theoretical and methodological issues throughout the study, which requires a clear rationale for such decisions”. Furthermore, qualitative research must incorporate researcher reflexivity so that the personal experiences, beliefs and assumptions of the researcher can be recognised as factors that shape the frame of, and approach to the research study itself (Willig, 2013). To incorporate these principles of qualitative research, the format of this chapter aims to combine both the theoretical underpinnings of the research methodology with the reporting of the researcher’s reflexive audit trail. In this way, the constant reflexive commentary will allow for the trustworthiness of the findings to be established throughout the chapter. By means of establishing the origins of that reflexive audit trail, the researcher’s personal history and point of departure will be discussed first in order to make overt the fact that, in qualitative research, the researcher cannot be assumed to be a neutral and objective observer (Nowell et al. 2017; Willig, 2013).

### **Researcher’s Reflexive Ontological Foundation**

According to De Gialdino (2009), qualitative research must ask the question of how epistemology and ontology have contributed to the production of knowledge, and therefore, epistemological reflection asks the following questions:

- How reality can be known;
- The relationship between the knower and what is known;

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- The characteristics, the principles, the assumptions that guide the process of knowing and the achievement of findings; and
- The possibility of that process being shared and repeated by others in order to assess the quality of the research and the reliability of those findings.

The rationale for the inclusion of the following details of the researcher's life will become clearer when reading the findings and the discussion chapter. This section will be written in the first-person to facilitate an ease of expression.

### ***Researcher's Personal History:***

I was born, raised and schooled in Pretoria, completing my tertiary education at The University of Pretoria. My nuclear family consisted of my mother, my father, and my younger brother.

My nuclear family household was one that was strongly rooted in the Christian faith, and as such, we grew up knitted into a Baptist church community. My parents were both leaders in the church setting, which made church involvement a large part of our lives. In my teenage and adult years, I joined a more charismatic church, which I still attend. My aunt and uncle founded a church in Kyalami which my uncle pastored until he passed away tragically in 2005. The two families had a close relationship and spent much time together.

My father, an aeronautical engineer (PhD) by profession, led the missions outreach programme at the church from before I was born (born 1983) until my early teenage years. He led this programme, because he was deeply troubled and concerned about what was happening in our country at that time. Every Saturday, he would take a group of church volunteers out to Kwa'Mhlanga, which was a homeland during that era. Out of choice, my brother and I would accompany my father on these trips as we had established relationships with some of the children and the families in this area, and we enjoyed spending time with them. While in Kwa'Mhlanga, we would assist the volunteers to build small houses, repair broken ones, and bring food to those who were poverty stricken. Many times we were invited to stay the night at the house of the pastor of the church in Kwa'Mhlanga which we were supporting. My brother and I would stay with my father at Pastor Johannes Mashaba's home, developing a deep respect and love for him and his family. This community is one that I still have memories of, that I associate with an ingrained sense of social injustice, and a community that was formative in developing my character.

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During this time (age 0 – 7) my mother was equally devastated by the practice of Apartheid. Being an educator, she was particularly distressed by the fact that black<sup>1</sup> children were not receiving the opportunity to receive the same education as white children. When I was 7 years old, my mother took this distress and channelled it into founding a low-fee private high school for black teenagers, who lived primarily in Mamelodi and surrounding areas. My father joined her as the director of the school in 2000, and they ran the school together from then onwards. The fee structure was created to make a quality form of education completely affordable for the parents. This meant that the school was able to pay my parents a sufficient salary for our needs, but there was no excess available, and so we lived a comfortable but simple life during that time. From the age of 7, I was involved in this school in almost every aspect, we were exceptionally excited about this venture and wanted to assist in any way that we could. In the early days, my brother and I would make photocopies, or pack shelves, which progressed over the years to me being a consulting clinical psychologist, and him being the business development manager. I suppose one can say that the school was so much a part of our fibre that we wanted to be part of its cause. The early days were tumultuous ones in both the political and social sense. I have memories of my parents receiving bomb threats and evacuating the school, memories of school parents sacrificing everything in order to give their children this education, memories of us fostering a teenage pupil who was being severely abused by her father, memories of the first matric dance, and the look on those students' faces when they had passed their matric year. As one can imagine, the school has been one of the most dominant parts of my life and has shaped some of my views, my experiences, my thinking, and my reality. Not only is the school a formative influence in my life, but I was raised, essentially, in a home of activism and leadership, which impacted me in a profound and irrevocable way. In fact, my parents were at the forefront of protesting against Apartheid when they studied at the University of Witwatersrand from 1975 - 1981. I do not think their activism was ever rescinded, rather, I think it remains a powerful culture within our family, for which I am grateful.

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<sup>1</sup> Please note that the use of the terms black, white, coloured and Indian are culturally acceptable terms in the South African context and are used to indicate classification of race. These terms do not carry emotional connotations, they are neutral terms and are not seen to be derogatory, as may be the case in other parts of the world. The coloured racial group is traditionally known as mixed race, but is referred to as coloured in South Africa. For the sake of consistency, though, these classifications (apart from Indian) will not be capitalised throughout this thesis.

Although South Africa has shifted in the last 27 years, the school still provides a low-fee, quality education product to their parents, and houses about 1200 pupils in total. The addition of a primary school in 2015 meant that I was consulted more often in my professional capacity, especially considering that my husband is the principal of the primary school. Therefore, I have spent many hours with parents of primary school children, the parents being a similar age to me. This is relevant, because I often encounter references made to South Africa's past, and I have had some insight into factors that continue to impact South Africa.

### **Rationale for Study from an Ontological Perspective:**

From a young age, I was drawn to the pain of others, which was most likely influenced by my upbringing of an overt practice of social justice. I was drawn to the fields of Medicine and Psychology, but chose the latter out of a desire to work at an intrapsychic level with emotional pain and trauma. When I was accepted into Masters for clinical psychology, I began to be exposed to some of the perceptions inherent in the field of Psychology towards religion and spirituality, especially Christianity. At the same time, the fact that I was going to qualify as a psychologist was not always welcomed or encouraged within the Christian community. I felt as if I was "different" as a psychologist, because I was a Christian; but that I was also "different" as a Christian, because I was a psychologist. This led to me being on the receiving end of many comments and criticisms by people in both those spheres of my life. Considering my exposure to human suffering as a child, I held an unshakeable belief that my Christian values and my professional skill were intrinsically linked within myself, and could be used to alleviate such suffering. Having had an uncle, Pastor Ross Hunter, in full-time ministry, and having spent much time with Pastor Mashaba, I had engaged in discussions around this dynamic with them both. My uncle in particular, whom I was extremely close to, frequently challenged to me to consider the interface of faith, human suffering, and the calling over my life, the remnants of these discussions with him still impacting my life today. The conversations I had with both of them revealed shared points of agreement and disagreement, but the atmosphere of the discussion remained one of mutual respect.

In some ways, I felt unnecessarily alienated by both my profession and some individuals within the church. This has changed over the years though, I have personally experienced the church being far more open to my professional standing, and I have churches that refer to me often. The pastors who refer congregants to me, though, are pastors with whom

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I have a long-standing relationship. I have seen shifting in my professional realm too, but not to a massive extent.

All of these factors have been pivotal in building my desire to embark on a PhD study in this subject matter. However, I think the primary catalyst to the title of this thesis was rooted in a personal tragedy. In 2013, I already had two beautiful girls, aged 3 and 2. I fell pregnant with our third child and gave birth to a son in April 2013. Samuel-James was a beloved son, and my entire family was besotted with him. However, there was a swine flu outbreak in Pretoria a few months after his birth, and he contracted the virus. With his immune system being compromised by the swine flu, he developed three other comorbid respiratory viruses. Tragically, he succumbed to these viruses a few weeks after infection. I will not attempt to articulate the meaning and the impact of this loss on all of us, it goes beyond description. What it did cause, though, was a T-junction point in my life, because I needed to draw on some kind of framework to bring myself, our families, and our friends through the trauma. In the moment of his death, I did not draw on psychological theory, I drew on my Christian faith. My husband and I relied on our Christian beliefs in trying to make sense of the loss, and in bringing us through the days that lay ahead. A colleague of mine suggested that we see a Christian trauma counsellor two days after Samuel's passing, which we did. However, it was not a helpful experience at all, and left us feeling more traumatised than debriefed. We had to help our girls to deal with the loss of a brother, and we had to find healing for ourselves too. In the weeks that followed the funeral, I was able to see how the interconnectedness of faith and psychological science became the most useful framework for us to draw from. Although the initial session with that trauma counsellor had been unhelpful, the psychological intervention that we used moving forward was hugely valuable. I could see the way that the two systems could coexist to bring maximum healing to our family, which left me concerned about the times in which potential integration was thwarted.

I had been in many professional contexts, including my own private practice, where I had heard psychologists making statements in a professional setting or to clients themselves about the opinion that "God does not exist", or that religion is redundant. Clients would come to see me in my practice and would report that their previous psychologist or psychiatrist had disallowed them from mentioning their faith, or had made derogatory comments about their beliefs, even though it was integral to their worldview. Similarly, I had sat in many church services where I had heard the pastor make statements about psychologists, Psychology, Psychiatry and medication, all of which undermined and vilified the field. However, these were

not the only experiences I had had; there were times when I worked closely and effectively with churches. There were also times where mental health professionals were respectful of clients' religious or spiritual beliefs, and felt it was pivotal to understand these beliefs in the course of the clients' treatment. With this, came the question that I had frequently asked myself: "Are the two fields at odds with one another?" and, "How do we create a space where there can be an appreciation for both?" I was keenly aware of the fact that South Africa is considered to be a conservative country with the majority of the citizens adhering to some form of religious affiliation. I had also spent much time in churches located in rural areas throughout my life, which gave me an inkling of religion and spirituality from an alternative viewpoint. I wanted to gain a comprehensive impression of these dynamics, how and why they operate, what forms they take, the experiences of others, the development of meaning, and the implications of this for a South African context. One of the main implications of this research would have to address the ethical practice of psychologists and the ethical treatment of clients according to statutory requirements. These questions were best answered by conducting my own research in the form of a PhD. I began to read about this subject matter more extensively but had to put the registration of a PhD on hold, because of the birth of our fourth child, the blessing of another son in 2014.

These are the central events and experiences that have formed my own ontological and epistemological basis. My intention with this PhD has not been driven by a specific agenda or hypothesis in mind, but has been driven by my determination to gain comprehensive insight and understanding about how perceptions can mould attitudes and behaviour, as indicated in the problem statement, Section Six of Chapter One.

This research process has evoked poignant responses within me, it has challenged me, it has surprised me, it has excited me, it has saddened me, and it has intrigued me. Due to the reflexive nature of qualitative research, I have offered the reader a transparent account of my responses at junctures where it has been most prevalent which will serve in solidifying the trustworthiness of the study.

### **Section Three: Aim of the Study**

The aim of this study is to provide a rich, in-depth thematic analysis of how Christian church leaders and psychologists perceive the role of religion and spirituality in mental health interventions within the South African context.

### **Section Four: Objectives of the Study**

The main objective of this study is to provide an in-depth and comprehensive review of the perceptions of Christian church leaders and psychologists towards the role of religion and spirituality in mental health interventions, and to review the implications of those perceptions.

To meet this central objective, there are three subsidiary objectives that must be met so that the main objective can be thoroughly examined.

#### **Subsidiary Objectives:**

- To determine the perceptions of Christian church leaders and psychologists towards the role of religion and spirituality in mental health interventions
- To determine how these perceptions influence the practice of both Christian church leaders and psychologists
- To determine whether or not these perceptions are conducive to the formation of effective mental health interventions for religious and spiritual clients within the South African context

### **Section Five: Research Question**

#### **Main Research Question**

- How do Christian church leaders and psychologists perceive the role of religion and spirituality in mental health interventions for clients?

In order to answer the main research question effectively, secondary research questions were posed to ensure the comprehensive gathering of data related to the main research question.

### **Secondary Research Questions:**

1. What are the perceptions of Christian church leaders towards the field of Psychology?
2. What are the perceptions of psychologists towards religion and spirituality?
3. How do the perceptions of Christian church leaders and psychologists impact the nature of the role that religion and spirituality plays in Psychology?
4. What impact do the perceptions of Christian church leaders and psychologists have on the psychological treatment of religious/spiritual clients?
5. What impact do the perceptions measured in the research have on the efficacy of the field of mental health services and service delivery to clients for whom religion and spirituality is important?
6. Is there a need for psychological and psychotherapeutic interventions to be more inclusive of religious and spiritual beliefs of clients?
7. What are the differences and similarities in the perceptions of the psychologists towards various faith traditions (Hinduism, Buddhism, Traditional African Beliefs, Christianity)
8. What are the perceptions of the psychologists and the church leaders towards one another and how does this impact interdisciplinary collaboration?
9. Is the field of Psychology in South Africa sensitive and adaptive to a person's constitutional right to freedom and expression of religion?

### **Section Six: Research Procedures: Phase One: Pilot Study**

The research was divided into three main phases. The first phase required a pilot study to be conducted to determine the feasibility of the study. The second phase of research proceeded based on pilot study considerations and entailed the data collection for the main study. The third phase was one in which the data could be analysed, and findings could be reviewed by the end of that phase.

## **Pilot Study Design**

The methodology and research design of the pilot study were based on the proposed methodology and design of the main study. The primary research design for the pilot study was a qualitative descriptive one.

## **Pilot Study Sample Selection**

The participants were selected using convenience, snowball selection techniques based on the researcher's professional networks at the time. Two psychologists, one clinical and one counselling, agreed to be part of the pilot study. One of these psychologists was a male, the other was a female. Two pastors, both leaders of large congregations, agreed to participation, both of whom were male. Although the research protocol aimed at interviewing participants from various ethnic backgrounds, the participants that acquiesced to their involvement were all from one ethnic grouping. The researcher attempted to widen this sample, but was unsuccessful, which became a limitation of the pilot study. With this in mind, the sample selection procedures were carefully reviewed for suitability within the main study procedures, because the pilot study indicated that it may be difficult to secure sufficient and appropriate participants when using convenience, snowball sampling.

All the selection criteria as set out for the main study in the next section, Section 7, were applied to the selection of participants for the pilot study. The pilot study interviews took place at a venue of the participant's choice to ensure their comfort and convenience. The pilot study participants were from the Tshwane area, this was because the required pilot study sample size allowed for the researcher's professional network within Tshwane to suffice as a selection pool. However, the participants selected for the main study were from three provinces, not just from Tshwane. The shift in sampling from Tshwane in the pilot study to sampling across three provinces in the main study will be discussed in Section Seven.

## **Pilot Study Data Collection**

The pilot study was conducted with the use of in-depth, semi-structured interviews. The interview question protocol was tested during the pilot study for its feasibility and its efficacy in eliciting the required information from the participants. The clarity of the questions, and the

ability for the researcher to communicate these questions clearly was also reviewed. These participants were invited to comment on their experiences of the interview so that the researcher could make any changes that were suggested.

### **Pilot Study Data Analysis**

The interviews were recorded, and then submitted to a professional transcribing company to be transcribed. Once the transcriptions had been completed, the researcher reviewed the transcriptions and made the necessary corrections.

The initial data analysis procedure that was suggested in the research proposal was grounded theory. The researcher was of the opinion that grounded theory would be appropriate in forming a theory about the perceptions of the psychologists and the pastors. When analysing the pilot study sample, the researcher was able to determine that grounded theory was not the most appropriate method for analysis. This was demonstrated by the fact that the researcher felt as if the data had to be forced into the format of a substantive theory. This process detracted from the primary objective of gaining an in-depth understanding of the meaning and perceptions of the participants in relation to their existential realities. Therefore, the researcher discussed this concern with the supervisors for the study, and justified the applicability of thematic analysis over grounded theory for the main study.

### **Implications of the Pilot Study for the Main Study**

There were some differences in the pilot study procedures in comparison to the main study, because the pilot study revealed areas where the methodology had to be reviewed.

- The migration from a grounded theory approach to thematic analysis impacted the research design. Whereas the pilot study was qualitative, descriptive, and embedded in a grounded theory approach; the main study design was an essentialist, inductive one, based on thematic analysis. However, the main study still retained a qualitative and descriptive foundation;
- When the interviews were transcribed by the professional transcribing company, it was determined by the researcher that the quality of the transcriptions was noticeably poor. The researcher, in fact, had to re-transcribe one of the interviews

to ensure its accuracy. Therefore, the main study interviews were sent to a different transcribing specialist to ensure maximum quality;

- Although generalisability was not the main focus of this study, the researcher still required interviews with people from various ethnic backgrounds in order to make the data as rich as possible. Considering that this was not possible in the pilot study, and was a limitation of that study, the researcher spent a considerable amount of time in securing a more suitable sample for the main study;
- The participants were invited to provide commentary about their experiences as participants. Two of the participants told the researcher that she clustered and linked her questions instead of asking one concise question at a time. On review of the recordings, the researcher realised that she had done this in her questioning style, which forced her to modify her approach when interviewing participants in the main study;
- The pilot study results were presented at four conferences before the main study proceeded, the details thereof will be discussed in Section Nine. The feedback that colleagues and professionals gave the researcher about the study was discussed with the PhD supervisors, and was applied to the main study methodology accordingly;
- As mentioned in the pilot study research design section, the initial methodology that had been chosen was grounded theory. However, this proved to be a cumbersome methodology to apply to the interviews, it did not serve in answering the research question as precisely as what the researcher intended. The purpose of the study was to establish and report on an in-depth understanding of perceptions and experiences, this was better achieved through thematic analysis than grounded theory;
- The findings of the pilot study, once presented at the conferences, were published in the following publication:
- Greyvensteyn, W. L. (2017). The ethical integration of religion and spirituality in mental health within a South African context, with an emphasis on Christianity. In A. De la Porte, A. Oberholzer, and N. Joubert (Eds.), *Proceedings of 2nd Biannual South African Conference on Spirituality and Healthcare*. Newcastle upon Tyne, United Kingdom: Cambridge Scholars Publishing.

### **Section Seven: Phase Two: Main Research Procedures**

Once all the above mentioned factors from Phase 1, the pilot study, had been considered, the main study commenced. Phase 2 involved the selection of participants for the main study and the collection of data. Phase 3 involved the analysis and reporting of this data.

#### **Participant Population**

The population from which the sample for this study was drawn consisted of two main groups. A group of registered psychologists was chosen to participate, and a group of pastors of Christian protestant churches was selected. The selection criteria for both the group of registered psychologists and the group of pastors will be discussed in this section.

Both groups of participants were fluent in English, although for some, English was not their primary language. Both female and male pastors had been invited to participate in the study, but only male pastors responded, and the pastors group therefore had no females represented.

Both male and female participants were included in the psychologists' sample, all of whom were registered with the Health Professions Council of South Africa. The psychologists had no ethical transgression investigations lodged against them at the time of their interviews.

#### **Selection of the Participants**

The participants were selected through two main methods. Firstly it was decided to begin the data selection procedure through purposive sampling. Neuman (2007) refers to purposive sampling as a method that is used by researchers who want to select participants according to a specific purpose. This makes selection clear, depending on whether or not participants meet the criteria required to fulfil that purpose. In this study, purposive sampling was appropriate, because the selection criteria set out above made the necessity to find informative and suitable participants essential. This sampling is described by Schreier (2018) as a procedure of sampling that emerges over the span of the study as the research continues, depending on what is required for the research. It was the researcher's initial design to request participation in the study from identified participants that met the selection criteria. Therefore, 25 email requests were sent out in the hope that at least 10 would reply, however, that was not

how the process unfolded, which is why the method of sampling developed over the course of the study. This process will be reviewed below.

### *Sampling Process*

Initially, based on the sampling process obstacles encountered in the pilot study, the decision was made to use purposive sampling in the main study by acquiring the names and details of psychologists who held academic positions at South African universities. Those psychologists were then screened according to their suitability for the study with the following criteria:

#### *Sampling of psychologists*

- Only clinical and counselling psychologists were considered because the focus of the study included discussions primarily around adult clients. The scope of practice for psychologists in South Africa makes it more likely that clinical or counselling psychologists will have maximum access to adult clients;
- The academic positions held by the participants had to include current or past exposure to the training of Masters level students;
- Not only was there a need for the participants to be embedded in an academic institution, but they also had to demonstrate their experience in the realm of private practice;
- The participants had to have obtained a PhD in Psychology, or be in the final stages of producing a PhD;
- The Health Professions Council of South Africa (HPCSA) had no pending ethical investigations lodged for the participants;
- The religious and spiritual views of the participants had no bearing on their selection for the study. The intention of the study was not to gain insight into the perceptions of psychologists from a specific faith tradition, but rather, it was hoped that there would be a representation of many faith traditions present in the sample. Therefore, in the request to participate in the study, the following sentence was included: Please note that your own personal religious or spiritual beliefs do not form part of the selection criteria for this study and have no bearing on your suitability to participate; and
- The requests for participation were intentionally sent to psychologists from a variety of racial groups. The purpose of this study required the participants to be

able to give their opinions and perceptions specifically in relation to a South African context. The researcher felt strongly that the sample group should, therefore, be as reflective as possible of the main racial groupings in South Africa. The researcher would have preferred to have had a more representative sample than what the main study entailed, but this was dependent on which participants agreed to be involved in the study, which was outside of the control of the researcher.

Although numerous requests for participation were circulated to various Universities in South Africa, the response to those requests for participation was minimal. The responses that were received were primarily in decline of the request. In fact, there were a few responses emailed that were overt in their opinion about the study:

- “You are very brave..... this is contentious..... I do not want to be part of your study”(via email)
- “I do not believe that religion and spirituality has any place in the field of Psychology and therefore I will not be part of your study.”(via email)
- One of the psychologists invited to participate abruptly declined the invitation and then blocked the researcher’s email address so that no further emails could be received from the researcher.

When it became clearer that the method of requesting participation for this study through the use of emailing was not yielding many responses, the researcher reviewed the suitability thereof. The most suitable method of selection under the circumstances described was snowball sampling. Snowball sampling (Neuman, 2007), is also referred to as network or reputational sampling, because the selection of participants starts with a few individuals and then proceeds from that point onwards based on who is connected or linked to that initial individual. Each participant is linked to the next participant either directly, or indirectly, and can be recommended or suggested to the researcher for consideration. As Babbie (2005) explains, there are times in which the population required for research is hard to reach, which makes it necessary to depend on the participants themselves to suggest other suitable candidates for the research. In the light of the poor response to the email requests for interviews, the population required was deemed to be “hard to reach”. The researcher, therefore, considered her own professional network and contacted a colleague at a University in a different province to ask if that colleague could suggest any professionals that met the stipulated criteria. The

researcher also contacted the head of the department of Psychology at the institution where she had completed her undergraduate and graduate training to request assistance in suggesting suitable participants in academia.

In the interim, there had been two psychologists who had accepted the invitation to be part of the study via email, and so the interviews with those psychologists proceeded. As part of the interview process, the researcher asked the participants if they could recommend any suitable candidates for the study from within their professional networks. The sampling continued from this point by the researcher contacting all the candidates that the people within her own network, and the networks of colleagues or the interviewed participants, had suggested. This snowball sampling produced a far wider pool of willing participants that the researcher could screen according to the criteria and then request an interview with. In the final analysis, there were three main networks that informed the selection of participants, and these networks were based in Tshwane, KwaZulu Natal and the Cape. Therefore, although the researcher initially thought that the sample would come mainly from the Tshwane area, the necessity to incorporate snowball sampling meant that the participants resided in different provinces to the participants in the pilot study. The biographical data of the psychologist participants has not been included in this section, because the majority of them were concerned that it would compromise their anonymity.

### *Sampling of pastors*

The sampling method for the pastors was similar to that of the psychologists. The sampling was purposive in that the researcher required particular participants who met the criteria as set out below:

The terms “Christian” and “church leader” are broad ones that could have allowed for divergent interpretations. Therefore, the sample of Christian church leaders sought was for participants who firstly fit the description of a Christian according to the following definitions:

1. A person who believes in and follows Jesus Christ and has made a commitment to following Jesus Christ;
2. A (current) member of a Christian Church or denomination;
3. The church group or denomination had to fall within the Evangelical Protestant subgroup of Christian churches;
4. The term “church leader” would refer to a pastor or elder of a church who is in full-time ministry for that congregation;

5. The pastor or elder would not only need to be in full-time ministry within the church where he or she is placed, but would also be required to interact and be involved with the church congregants. This interaction and involvement would need to include but not be limited to pastoral functions such as regular preaching, leading the church team, visiting the sick or “in need” congregants, and engaging in pastorally based guidance of the congregants. A minimum of five years in ministry was required for participation; and
6. Additional training or a special interest in the subject of mental health was not a requirement for the church leader’s participation. The researcher’s aim was to interview church leaders in their position as church leader, regardless of their training or interest in mental health.

The term “church leader” was originally used in the request for participation in order to circumvent the many terms used within different churches to identify the church leader. However, each church leader who participated was referred to as the “pastor” in their church, or was comfortable with the term “pastor”, which allowed for the term “church leader” to be replaced throughout the findings chapters with the term “pastor”. As mentioned, the method of participant selection was purposive for both the pastors and the psychologists. However, there was a difference in sampling between the groups. Snowball sampling was more prominent from the beginning of the selection process for the pastors due to the fact that the pastors seemed more anxious to be interviewed by a psychologist than the psychologists themselves did. The researcher approached a few pastors in person to give them the information about the study and to request their participation. Some of those pastors knew the researcher in a professional capacity, but some of them did not. The pastors who knew the researcher (4 in total) were considerably more willing to be part of the study in comparison to the others. Therefore, observing the pastors’ responses to the researcher’s request for participation made it clear that snowball sampling would be necessary to secure interviews. The researcher contacted the pastors with whom she had a professional relationship and asked them if they could suggest other pastors on the basis of the set-out criteria. This was, therefore, the primary method of selection by which the pastoral participants were selected. The pastors also spanned over three primary provinces; Tshwane, KwaZulu Natal, and the Cape. The demographic particulars of 8 of the 9 pastors interviewed has been included in this section, because these pastors gave their consent and did not think that it compromised their anonymity.

*Table 6*  
*Demographic Particulars of the Pastors in the Sample*

<b>Pastor</b>	<b>Age</b>	<b>Ministry Years</b>	<b>Race</b>	<b>Gender</b>	<b>Province</b>
1	35	8.5	Coloured	Male	Gauteng
2	49	25	White	Male	Gauteng/ KwaZulu Natal
3	57	18	Coloured	Male	Cape
4	52	28	White	Male	Eastern Cape
5	52	27	White	Male	Cape
6	58	21	White	Male	KwaZulu Natal
7	33	9	Black	Male	Gauteng
8	69	30	White	Male	KwaZulu Natal

### **Method of Data Collection**

Considering that the aim of this study was to gain comprehensive information from the participants, the use of semi-structured, in-depth interviews was used for data collection as it is purported to be the method of analysis that best elicits the rich perspectives of participants (Marks & Yardley, 2004). Yin (2016) states that the use of an in-depth interview is appropriate in the context of social research when the purpose of data collection is to give expression to the beliefs, views and explanations of the participants. Not only does an in-depth interview give expression to the participants' realities, but it also creates the opportunity to study phenomena that are not directly observable and allows the participant to be the informant of these phenomena (Taylor, Devault & Bogdan, 2016). With the method of data analysis being thematic analysis, which is a form of discourse analysis, Yin (2016) explains that a narrative form of inquiry through the use of an interview allows the researcher to analyse the words, phrases and vignettes, provided by the participant, so that the reality of that person can be understood by the researcher. However, a full and comprehensive analysis of the interview data can only be effective if the nonverbal cues present in those interviews are analysed parallel to the spoken words and phrases, which makes it necessary to observe body language, tone of voice, and displays of emotion in the interview (Yin, 2016).

For the purposes of this study, a structured interview would not have allowed the researcher enough flexibility in questioning. Rather, a semi-structured or qualitative interview (Yin, 2016) was the preferred method of data collection, because it allowed for a conversational atmosphere where the researcher and participant were able to explore information specific to that participant's existential reality. The researcher had a well-defined area of inquiry that included some standard questions, but allowed for the flow of conversation and data collection to evolve from that point onwards (Taylor et al., 2016). With all these factors considered, an in-depth, semi-structured, qualitative interview was used as the method of data collection in this study in order to gain insight, understanding and knowledge about the perceptions of both pastors and psychologists.

Babbie (2005) explains that the presence of the interviewer should not influence the interviewer's understanding of, or the response to the question. Although this was my intention as the interviewer, I could perceive that some of the pastors, in particular, seemed uneasy in the interviews. This was demonstrated by phrases such as "I don't know if I am allowed to say this", or "I do not want to offend you or your profession". I responded to the uneasiness I perceived by reassuring them that my role as the interviewer was to gain as much information as possible and to deepen my knowledge of this subject area. I encouraged them to be as honest and forthright as they desired and to censor their responses to the questions as little as possible. This seemed to place some of the pastors more at ease, and the interviews flowed well from that point onwards. Although the psychologists did not seem apprehensive to be interviewed, they were verbal about the fact that the topic of the interview was a contentious one.

### *Interview protocol for pastors*

The interview used was semi-structured in nature and comprised of a few main questions for both the psychologists and the pastors, which included but was not limited to the following questions:

Pastors:

1. What are some of your initial thoughts when you hear the terms religion, spirituality, Christianity, and Psychology alongside one another?
2. What type of relationship do you think that these disciplines have with one another and why is it so, in your opinion?

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3. Do you have concerns about the field of Psychology and Psychiatry? If so, what are those concerns?
4. Do you think that the field of mental health is beneficial to your church context? Please give a reason for this answer.
5. How do you communicate about mental health issues to your congregants/people within your sphere of influence?
6. What are some of the ways in which you would handle a congregant/person who reports to be depressed or anxious (for example)?
7. Have you had specifically negative or positive experiences with mental health professionals, or the way in which they have interacted with your congregants/people?
8. What do you foresee as the most desirable relationship between the fields of religion and mental health?

These questions were sent to the pastors before the scheduled interview, because the pastors asked me about what type of questions they would be asked, and so I considered their desire to be prepared for the interview. However, not all the pastors received this email due to administrative or technical mishaps, or they were unable to review the questions before the interview took place. Furthermore, the interviews were conducted in a conversational manner and so it was not possible to predict the types of questions that would flow from the conversations. Therefore, their answers were largely unscripted and were not predetermined.

### *Interview protocol for psychologists*

1. What are some of your initial thoughts when you hear the terms religion, spirituality and Psychology (or mental health) alongside one another? Please give a reason for your answer.
2. What is your perception of the role of religion and spirituality in promoting a client/patient's mental health? Please give a reason for your answer.
3. Do you believe that a patient/client's religious and spiritual beliefs impact on the presentation, diagnosis and treatment of psychological disorders? Please give a reason for your answer.
4. Is a religious or spiritual dimension to client/patient care included in your institutions' undergraduate or postgraduate curricula for Psychology? Please expand on this answer.

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5. What have your experiences been of how faith traditions approach issues of mental health? (Both positive and negative)
6. Have you had any experiences of how psychology and issues of mental health have been integrated into protestant evangelical churches? Please expand on this.
7. Have you encountered any specific form of religion or spirituality that is viewed differently by you than other forms? Please give a reason for your answer.
8. What do you foresee as the most desirable relationship between the fields of religion and mental health?

The main questions were emailed to the psychologists before the interview for the same reason that the questions were emailed to the pastors. Similarly to the pastors, not all of the psychologists received the emails, or they were not able to create time in their schedules to review the questions before the interviews took place. This meant that the psychologists' answers had also not been scripted by them before the interviews took place.

All of the questions to the psychologists and the pastors were open-ended, or at least facilitated a discussion around the question that was posed. Depending on the answers that the participants provided, the researcher would provide prompts or clarifying questions to enable further dialogue. The interviews differed in length from participant to participant, depending on the flow of conversation. The average time for the pastors' interviews was between 70 – 90 minutes, with one interview being over three hours long. The average interview period for the psychologists was 80 – 120 minutes. The interviews were digitally recorded, which was included in the consent form that the participants signed before the interview commenced. Once the interviews had been recorded, they were sent to a transcribing professional who transcribed the interviews verbatim. The transcriptions were given to the researcher to be edited, which was done by listening to the recording again and comparing it to the transcription. The researcher made all the necessary changes to each transcript and only began with coding once the transcripts were precise.

### **Section Eight: Data Analysis: Thematic Analysis**

As discussed in Section One, the purpose of this study was to embed the researcher in the participants' world of experiences, perceptions and worldviews. The finding of the meaning in what each participant said was of the utmost importance and created the foundation on which the study proceeded. The method of data analysis, therefore, had to be one that allowed for the researcher to carefully review both an obvious meaning to statements and the more implicit meanings given. Thematic analysis was the method of data analysis that was chosen for a few primary reasons:

- Thematic analysis is not embedded within any specific theoretical point of departure which allows it to be a flexible form of analysis that can be used within many various theoretical frameworks (Braun & Clarke, 2006);
- Thematic analysis is well suited to studies within the spheres of health and clinical psychology (Marks & Yardley, 2004);
- Thematic analysis is a qualitative method of research that allows the researcher to interpret the meanings given by participants, and to interpret the nature of their experience. It is a method that can be used to generate valuable information and knowledge within the context of mental health studies (Crowe, Inder, & Porter, 2015);
- When using thematic analysis in a rigorous and methodical way, it is a trustworthy way to produce meaningful and valuable research results (Nowell, Norris, White & Moules, 2017);
- The use of thematic maps and/or thematic networks in thematic analysis provides a useful and coherent depiction of the research results in a way that becomes useful to the reader (Attride-Stirling, 2001); and
- The use of a rigorous approach to thematic analysis can produce results that are insightful and valuable for the field of Psychology. This form of analysis provides the researcher with patterns of data and understandings of the meaning of data in a manner that applies to their research questions (Braun & Clarke, 2006).

Considering the fact that the main purpose of this study was to gain insight into the experiences and perceptions of two groups of participants, the requirement for a method of analysis that directly reviews meaning was critical. The research question referred to the perceptions of more than one person, implying that patterns of meaning would be sought throughout the two groups of participants so that conclusions could be drawn about a commonality (or lack thereof) of perceptions. When considering the six points above, it becomes clear that thematic analysis would align closely with the purpose of the study.

Braun and Clarke (2012) state that the approach to thematic analysis that is chosen by the researcher should be clearly stated and justified. To simply name thematic analysis as the main method of analysis is not sufficient in ensuring a rigorous approach. This study focused on the transcripts of interviews that were held with participants for the purpose of gaining insight into the meaning of their perceptions and experiences. The data coding was, therefore, based on the content of the data provided in the interview transcripts. Codes were drawn from the data, and then interpreted accordingly. In this way, the form of thematic analysis that was used in this study was an inductive approach where codes are both interpreted and generated from the data by the researcher. Furthermore, the epistemological approach to the inductive thematic analysis for this study was essentialist in nature, because meanings and experiences were theorised (Braun & Clarke, 2006). To mention the term “inductive essentialist thematic analysis” throughout the study becomes cumbersome though, and so the term “thematic analysis” will be used from this point onwards, but it must be noted that I am referring to an inductive and essentialist form of thematic analysis.

When it comes to analysis, Attride-Stirling (2001) states the requirements for conducting a full process of analysis when using thematic analysis that will ensure the text can be meticulously reviewed. Three steps to a full analysis are suggested to achieve in-depth analysis: a) reducing or breaking down of the text; b) exploring the text; and c) integrating the sections of text that have been explored. These three steps were followed in this study as an overarching basis in order to ensure that in-depth analysis was achieved. Within this overarching basis, the six steps to thematic analysis as described by Braun and Clarke (2006; 2012) were undertaken and will be reviewed in the next section.

According to Marks and Yardley (2004), thematic analysis allows for the interpretation of themes and categories through two main classifications of content in the data. The first classification is manifest content and refers to meaning that is clearly and overtly stated by the

participant and can be observed by the researcher. The second classification is latent content where the meaning of the data is implied rather than stated. In order for the researcher to effectively code the data, both manifest and latent themes should be found and interpreted by the researcher.

Throughout the findings and discussion chapter, there is a review of the manifest and the latent meaning of the quotes that have been coded. In order to remain constantly cognisant of the manifest and latent meanings that emerged from the data, the use of tables in the findings chapters have been used. In these tables, the content of the participants' responses has been provided with the corresponding manifest and/or latent meaning that was induced by the researcher. The context in which qualitative research takes place must always be considered alongside the interpretation of the data (Whitley, 2002), therefore, at various junctures in the findings, a column containing the context of the statement has been included. It must be noted that latent meaning was often indicated by the participant through the use of non-verbal forms of communication, for example: hand gesticulation, facial expression, tone of voice, varying levels of expressiveness (excited, disillusioned, traumatised), emotion present, and verbal utterances. These instances were included in both the interpretation and reporting of the data, because of the significant bearing of the meaning inherent in the statements provided. The researcher as the tool of research (Neuman, 2007) is a concept that became particularly evident in this study with how the latent data were interpreted. Being a clinical psychologist with ten years of experience, and continued professional development, places the researcher in a position where the non-verbal communication could simply not be ignored. The recognition of emotional experiences is something that the researcher is comprehensively trained in, and therefore it impacted on how this data were coded. Oftentimes, the non-verbal cues would determine the direction in which the interview proceeded by how the researcher observed the latent meaning in the participants' statements. Without the meticulous practice of using a memo during the interviews to record this non-verbal information, much of the latent meaning would have been lost.

### **Phases followed in Thematic Analysis**

The six-phase approach to thematic analysis was followed as denoted by Braun and Clarke (2012). The phases of their approach to thematic analysis will be numbered Phase 1 – 6 and the way in which this phase was applied to the study at hand will be discussed.

#### **Phase 1 - Familiarising Yourself with the Data**

In order to be familiarised with the data, immersion within the data is required. Therefore, the transcripts of both the pastors and psychologists were read numerous times in this phase alone. The first reading provided an overall impression of the transcripts. In the second reading, notes were made about patterns that had been noticed and possible codes that could be explored. The memos that were made during the interviews in a separate book by the researcher were incorporated into the readings of the transcripts so that non-verbal communication could be captured in the overall meaning-making of the transcripts. A second memo system was introduced and used during this phase so that notes on the data set as a whole could be recorded for further theme exploration. Notes of observations on the entire data set from the pastors and the psychologists, and the interaction between these data sets were captured on the memo.

#### **Phase 2 - Generating Initial Codes**

In this phase, the systematic analysis of the data took place through recognising initial codes for the data. All aspects of the data that were deemed to contain information relevant to the research questions were coded through the typing of these codes electronically alongside each line of the transcript. The initial coding phase was done according to both manifest and latent codes where the coding retained as much of the original content as possible. Many latent and interpretive codes were captured during this phase as well, which is why the memos made in the interviews were critical in uncovering latent meaning. Although Clarke and Braun (2006) suggest that thematic analysis focuses either on a descriptive form of analysis (semantic/manifest themes) or an interpretative analysis (latent themes), they mention that some studies, however, will require a combination of analysis at both these levels. This PhD study focused primarily on semantic and manifest meanings, but there were also times in which an interpretation of latent meanings was essential in order to contextualise the experiences of

the participants. When latent meanings were interpreted in the study, it was stated as such so that the analysis thereof could be carefully reviewed and understood.

The initial codes, therefore, were based on both the semantic, manifest meanings and the interpretive latent meanings that were found in the data. Codes were given to large portions of data and to shorter phrases that held significance, for example, “*it is a stigma*” was a phrase that was coded within a large portion of data relevant to a separate code, because the participant had referred to an emerging theme, being stigmatisation. In this way, more than one code was given to the same section of data in the initial phase if the data warranted such coding. New codes were generated in instances where existing codes were not appropriate and existing codes were modified to allow for the inclusion of new data. The codes were designed to be inclusive of as much data as was determined to be relevant, and to reflect patterns observable across all transcripts. An example of observable patterns is the way that the pastors’ data had to be coded to show that every pastor discussed referral in their interviews, demonstrating its relevance to the data as a whole. In this way, the codes continued to be developed throughout Phase 2. All coding was done manually and no computer software was used. In this phase, each transcript was coded on an A4 mind-map using different colours for each code present. The transcripts generated, on average, 15 pages of mind maps per interview transcript.

### **Phase 3 - Searching for Themes**

By using mind maps and colours to show the codes in Phase 2, it became visually easier to recognise where themes might have been observable from the data. All the themes had to include data that were directly relevant to the research questions in the study. This proved challenging, because the research question refers to “perceptions” which is a broad term. There are various ways in which perceptions can be discussed or intoned, for example, through a non-verbal gesticulation of judgment. The researcher had to be keenly aware of when participants were referring to a perception, either through manifest or latent descriptions, and then knit the codes into a coherent theme accordingly. The themes were constructed by the researcher based on the frequency to which certain codes were present, and were designed to capture the essence of the data being described. For example, the psychologists discussed their perceptions of pastors based on the direct or indirect experiences that the psychologists or their clients had undergone. Through coding these experiences, it could be seen that the perceptions were formed according to the valence that the psychologists associated with the experiences.

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Therefore the theme of valence was constructed by the researcher to differentiate between the nature of the perceptions (destructive and beneficial) and the context where the perceptions had been formed. Themes continued to be developed in relation to the research question, but it was noted that there were themes that overlapped at times. This overlap revealed the themes that would be integral in providing an overall, rational, and merging quality both within and between the two sets of data (pastor and psychologists). One such overlap was stigmatisation as a theme, and rigidity as a subcategory. The overlaps were discussed in the findings chapter so that the richness and prevalence of the theme could be shown. Although Braun and Clarke (2013) specify that each theme should be distinct and separate from other themes, they also specify that the themes should be linked in telling a story about the overall data.

The themes that were chosen for the purposes of this study were distinct, were coherently linked, but also shared some overlapping qualities. This is because the defining of “perceptions” is a complex process that involves many factors; some of these factors are inextricably related and therefore have roots in more than one theme. Furthermore, the research question necessitated the drawing of parallels between two separate data sets. This posed a challenge for the researcher, because the content and expression of data between the two sets of data was disparate. Where parallels and correlations could be seen between the sets of data, themes were accordingly structured to allow for further comparison and discussion. The themes that were interrelated were the themes that discussed stigmatisation, interdisciplinary collaboration, and the “worlds apart/unnamed conflict” category. The themes chosen, however, were not reflective of every piece of information generated from the data; the themes were carefully formulated in response to the research question posed for the study. For example, Pastor I spoke at length about the dissimilarities in the ontology of Psychology versus Theology, and Theology’s rejection of Psychology on the basis thereof. Pastor I spent approximately 25 minutes of the interview reviewing and explaining these differences to the interviewer, however, he was the only pastor who did so. No other pastors drew overt distinctions between the ontology of Psychology versus Theology. Therefore, where appropriate, this section of data could be incorporated (pastors’ theoretical foundations that guide interpretations), however, the remaining data in that section were discarded, because it did not hold direct relevance to the research question.

The use of Thematic Maps was incorporated in the conclusion section of each of the findings chapters as it structured the themes in a more logical format where the overall interconnectedness and meaning of the themes was shown. This aided the researcher in

displaying the rationale for conclusions that were drawn so that the audit trail was accessible. The Thematic Maps which draw the primary parallels between and recommendations for the two sets of data were included in Chapters Four and Five.

### **Phase 4 - Reviewing Potential Themes**

This phase of thematic analysis includes the review of themes in relation to the data that were coded, and the data sets as a whole, which ensures the quality of themes chosen. As Braun and Clarke (2012, p. 65) state “(this phase) is particularly important for novice researchers and for those working with very large data sets, where it is simply not possible to hold your entire data set in your head”. Considering that I am, relatively speaking, a novice researcher, and that the data consisted of two separate and large sets of data, I can comfortably state that it was a demanding task.

In order, therefore, to review the suitability of the themes, I created A3 mind maps of each set of data for each theme. Every quote or section of data that were suitable for these themes was transcribed verbatim onto the mind maps so that the quality of the themes could be evaluated. There were twenty-eight A3 pages of mind maps created for the psychologists’ themes, and twenty-three A3 pages of mind maps created for the pastors’ themes. Once this process had been completed, a framework was generated from those mind maps where each theme was named and the categories which presented with those themes were identified. In this way, it was possible to notice which themes were more suitable as categories, or which themes were too diverse. Some themes were thus renamed, collapsed into other themes, and split into a theme and a category. The themes were then modified accordingly so that each theme contained information that was useful to answering the research question, and the boundaries of each theme could be delineated. A content-based thematic map was drawn up which named the main themes, the categories under those themes, and the codes that needed to be accounted for within the categories.

### **Phase 5 - Defining and Naming Themes**

Once the themes had been reviewed in a content-based thematic map as described in Phase 4, the themes could be given final titles and definitions, capturing the essence of each theme. These content-based thematic maps containing the naming and definition of the themes,

and samples of the A3 mind maps generated in Phase 4, were submitted to the supervisors of this study for consideration and comment.

Although these initial thematic maps were well structured and were met with approval by the supervisors, the writing-up process revealed areas where the flow of the themes was lacking. By placing “body” onto the themes when writing them up, a thematic analysis of each theme ensued. This thematic analysis indicated which themes were over-inclusive, repetitive, or structured with cumbersome language. This was because the flow of the themes and categories became much clearer once they begun to be explained in the findings. To facilitate a comprehensive yet rational and logical flow to the explanation of the themes, the researcher made some changes to how the themes and categories were originally structured. The themes were also placed in an order that facilitated development from one theme to the next instead of a haphazard connection between the themes. A coherent story could therefore be created where the themes built on from one another and developed the connectedness of the data in reporting the findings. This phase was the most detailed of all the phases, because it required the deep analysis of data to determine which data would be quoted to best illustrate the analytic points that were stipulated. With the methodological requirement that themes be based on rich data that are present across the data sets (Crowe et al., 2015), the researcher included numerous quotes for each data extract. In this way, the narrative quality of each theme could be demonstrated and the interpretation of the data could be provided to display the overall conceptual framework. At points in which the researcher had applied an interpretation of latent meaning in data, this was so stated to allow the substantiation thereof to be understood.

### **Phase 6 - Producing the Report**

As mentioned in Phase 5, the producing of the findings chapters for this study was done in conjunction with the final phase of analysis. The writing of, and continual analysis of the data throughout the writing phase was a process that yielded further refining of themes and sub-themes. When writing the findings for the psychologists and pastors, the final thematic maps were modified when the flow between the themes became more apparent. The themes and subthemes were presented in the thesis in a way that allowed them to build on from one another, and to pave the argument towards an ultimate conclusion, which was represented diagrammatically for reader accessibility.

### **Section Nine: Ethical Considerations**

Allan (2011) reminds professionals within the field of Psychology that researchers in this profession should share a “common morality” (Allan, 2011, p. 112) when conducting research. At the centre of psychological research should be legal-ethical decision making, and a careful analysis of the impact that the research has on participants’ wellbeing. Therefore, decisions made within the course of the research should be congruent with these principles. This section considers the ethical considerations made by the researcher throughout the course of the study within the context of psychological research.

#### **Trustworthiness in Thematic Analysis**

Nowell et al. (2017) state that the proliferation of qualitative research studies gives rise to the necessity for trustworthiness and rigour to be in place so that the results of the research are meaningful. When it comes to thematic analysis in particular, Nowell et al. (2017) set out specifications for ensuring this rigour and trustworthiness, which will be reviewed in the light of this study and include the following:

- Credibility
- Transferability
- Dependability
- Confirmability
- Audit Trails
- Reflexivity as Central to Audit Trails
- Limitations of the Study
- Ethical Considerations

#### **Credibility**

To demonstrate credibility, Tracy (2010) discusses the requirement of the study to provide in-depth, rich, descriptive and thorough depictions of the data so that the reader can recognise the accuracy of the researcher’s interpretation of the participants’ meanings, and draw similar conclusions based on this information. Triangulation, as another means of establishing credibility, was addressed by the supervisors of this study having access to the process of interpretation, and providing commentary throughout. Beck (1993) provides a series of questions that the researcher needs to answer about his/her study to ensure that credibility

has been considered and established. The factors that were considered in this study, based on the questions posited by Beck (1993) are as follows:

- In-depth notes were kept by the researcher which recorded researcher-participant relationship factors. The researcher also recorded her subjective experiences throughout the research process, and the impact that these had on her. Notes were kept by means of two memo pads, one for the actual interviewing process, and one for the analysis of the data;
- The effects of the researcher on the participants was accounted for in the findings, methodology, and discussion chapters;
- Triangulation was used by means of the supervisors having continual and regular access to the data and the findings;
- The readers of this study were provided with numerous and rich data extracts to illustrate the points that had been made;
- Evidence that was contrary to the main themes, or data that discounted the main themes was accounted for and demonstrated in the findings chapters;
- The accuracy of the researcher's understanding of the participants' experiences and meanings thereof was constantly confirmed with the participant throughout the interview process; and
- A reflexive approach to this study ensured that the researcher could distinguish a separateness of her own experiences being merged with those of the participants. This was also demonstrated in the inclusion of the reflexivity section.

### **Transferability**

Qualitative research does not have transferability or generalisability as its main purpose, instead, this study deemed a smaller sample for the collection of in-depth information to be the most suitable approach to answering the research question (Buston, Parry-Jones, Livingston, Bogan & Wood, 1998). As such, it is not the researcher's intention to transfer these findings to a more generalised population. However, thick and rich descriptions of the data, and the data collection methodology, were provided so that future researchers can evaluate the suitability of the research to their own contexts.

### **Dependability**

The research process has been thoroughly and logically documented in this chapter; it has been presented in a logical manner so that the findings and interpretations can be traced. Providing an audit trail is one way of strengthening the dependability of the study, which has been incorporated in this chapter. As mentioned, an attempt to replicate this study to produce the same results would be redundant in the frame of qualitative research; however, the methodology for this study has been set out so that the procedures included could, theoretically, be used by other researchers (Buston et al., 1998). The way that the research was reported demonstrates its consistency, which bolsters the dependability of the study (Amankwaa, 2016).

### **Audit Trails and Reflexivity**

Nowell et al. (2015) consider the establishment of trustworthiness in qualitative research to be facilitated through the use of audit trails which can be followed by other researchers. Theoretical and methodological decisions made throughout the research process need to be substantiated with an explanation of the underlying rationale thereof. The style of writing for this methodology chapter, as discussed in the introduction, was aimed at providing an audit trail that was interwoven with the theoretical content by providing the researcher's personal commentary. In the methodology, findings and discussion chapters, researcher reflexivity was embedded within the content of the chapters, and was then assessed by means of the conclusions drawn from those chapters. The introduction of this chapter was a self-reflexive one so that the reader could be orientated within the researcher's existential reality, and ontological position. Reflexivity, therefore, has been threaded into the writing of this thesis in an integrative manner.

### **Confirmability**

Confirmability refers to the closeness of the researcher's interpretations with the data and the plausibility of the conclusions drawn (Nowell et al., 2017). In the findings chapters of this study, the interpretations made by the researcher were discussed in detail. When necessary, the role of reflexivity and the researcher's personal biases were made overt so that the reader could understand the context of the interpretation and the closeness of those interpretations in relation to the data extracts.

### **Limitations of the Study**

1. The purpose of qualitative research is not to attain representativeness of a sample in the same way that quantitative research does (Camic et al., 2003). The sample size is chosen depending on the research question, and on the judgement of the researcher, not for the intention to attain generalisability (Whitley, 2002). The findings of this study, therefore, cannot be said to be generalised to all psychologists and all pastors. Furthermore, perceptions are fluid, and can undergo constant change. Therefore, it is imperative that I reiterate that the findings for this study are valid only for the psychologists and pastors interviewed, for the time and context in which they were interviewed. The findings yield valuable knowledge that can inform future inquiry but do not indicate the perceptions of all pastors and all psychologists. It should also be noted that when referring to findings pertaining to “pastors” and “psychologists” in this study, it denotes only the pastors and psychologists that formed part of the sample group;
2. The sample of pastors included only pastors of evangelical protestant churches, because the sample had to be defined and delineated according to specified criteria. The inclusion of religious practitioners from various church groups or faith traditions would have complicated the study significantly, because the interview protocol would most likely have to have been modified for each of those variations. Therefore, the decision was made to define the sample according to one primary church grouping, implying that the sample could not include religious practitioners from innumerable faith traditions. It is possible that the findings would have differed considerably if religious practitioners from other faith traditions had been the focus of sample selection;
3. All the participants from both the pastor and psychologist sample volunteered their participation based on the information I provided them about the study. Therefore, it is possible that the participants volunteered their participation, because they had strong opinions about the subject matter or, because they had a special interest therein. The results may have differed if the sample group had contained participants that had been recruited in a manner that placed less emphasis on their willingness to participate;

4. It must also be clearly stated that, when using thematic analysis, the researcher is interpreting the meaning that a participant gives to an experience at a specific point in time. Crowe et al. (2015) reflect that a participant's perceptions to their lived experience can change over time, and that the same questions, when asked by a different person, at a different juncture in the participant's life, could potentially elicit varying responses from that participant. Meaning is a complex and dynamic entity, it is not static, it is open to amelioration through both internal and external factors. As mentioned in point number 1 above, the results of this study should provide a deeper understanding of perceptions and should guide further research initiatives, the findings should not necessarily be taken as an unchangeable status quo; and
5. The audit trail approach to the writing of this chapter was intended to provide comprehensive information about how the data were coded. The writing of the findings chapters also included numerous data extracts to substantiate the interpretative and inductive steps taken. This being said, one of the limitations to this study resides in the fact that the data were interpreted by one researcher which fails to allow for a multitude of opinions from other researchers (Fereday, 2006). The data, initial themes, subthemes, and preliminary findings of this study were reviewed and discussed with the supervisors for this PhD study, and were presented at six conferences in total before the main findings were written up. This process may partially have circumvented the limitation of interpretation by one researcher.

### **Ethical Considerations**

In my role as the researcher, my professional identity and training as a clinical psychologist could not be divorced from the ethical considerations underlying this study. The Health Professions Council of South Africa requires psychologists to follow specified ethical principles when conducting research, which I had to be cognisant of. Therefore, the ethical principles followed will not only be discussed in the broad sense of ethics in qualitative research, but will also be framed within the context of my statutory obligations as a registered psychologist. The table below and discussion that follows thereafter refers to my role as the

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researcher in the third person so that a parallel can be drawn between the quoted guidelines, and my incorporation of those guidelines in the study.

- In relation to: Ethical Considerations According to the Health Professions Council of South Africa, Guidelines for Good Practice in the Health Care Professions: General Ethical Guidelines for Health Researchers, Booklet 6:

*Table 7*

*Guidelines for Good Practice in the Health Care Professions: General Ethical Guidelines for Health Researchers, Booklet 6*

<b>Quoted Guidelines p. 1 - 3</b>	<b>Incorporation of Guidelines into Study</b>
<p>3.1. Researchers conducting health research involving human participants need to consider the possible adverse impacts of their research on vulnerable groups and thus have a duty to observe the highest possible standards to protect the rights of research participants</p>	<ul style="list-style-type: none"> <li>- All adverse impacts of the research on the participants were considered. The participants were offered counselling at the expense of the researcher in the event that the interview process was traumatic for them.</li> <li>- The counselling that was offered to the participants was organised to be facilitated by a clinical psychologist who had no knowledge of or involvement in the research process in order to ensure that there was no duality of roles by the psychologist or by the researcher.</li> <li>- No participants, however, requested counselling.</li> <li>- Some of the identifying biographical data or data extracts were modified to protect the anonymity of the participants. When this modification took place, it was stated in the findings.</li> </ul>
<p>3.2. Responsible health research not only makes a scientific contribution for the</p>	<ul style="list-style-type: none"> <li>- The researcher is of the opinion that this study contributes valuable scientific</li> </ul>

<p>good of humans or animals, but is also conducted in an ethical manner.</p> <p>3.3. For research to be ethical, guidelines need to be followed. Such guidelines flow from underlying ethical values, standards, and principles. Effective guidelines contribute to achieving health research that is scientifically, ethically and legally sound.</p>	<p>contributions to the field of Psychology, Theology, Psychiatry, and the social science fields.</p> <ul style="list-style-type: none"> <li>- The research was conducted in strict adherence to ethical requirements as stipulated in Section Eight and Section Nine of this chapter.</li> </ul>
<p>3.4. Health research ethics committees use a protocol review procedure to consider all ethical questions regarding human and animal health research proposals and protocols. According to the National Health Act (Act No. 61 of 2003), all health research proposals and protocols require approval by an accredited health research ethics committee before the research may commence.</p>	<ul style="list-style-type: none"> <li>- The research protocol and research proposal was submitted to both supervisors for this study, and accepted by them. It was then submitted to the research ethics committee in the Department of Psychology at UNISA where the ethical considerations thereof were reviewed. The ethical committee was satisfied with the protocols and gave permission for the research to continue.</li> <li>- The ethical clearance certificate for this study has been included in Appendix B</li> </ul>
<p>Section Four, p. 2 – 3</p>	
<p><i>4.1.1. The principle of best interest or well-being</i></p> <p><b>The principle of non-maleficence:</b> risks and harms of research to participants must be minimised.</p> <p><b>The principle of beneficence:</b> The benefits of health research must outweigh the risks to the research participants.</p>	<ul style="list-style-type: none"> <li>- The risks of harm to the participants were evaluated as being minimal. According to the UNISA risk categories considered by the ethical committee, this research was deemed to be Category 3, Medium Risk. This was due to the following factors:             <ul style="list-style-type: none"> <li>• There was a potential risk of emotional or psychological harm, or stigmatisation for the</li> </ul> </li> </ul>

	<p>research participants, however, the researcher was able to take the necessary steps to mitigate these potential risks as discussed throughout this table.</p> <ul style="list-style-type: none"><li>• The research topic was classified by the researcher to be “sensitive” in nature, because it involved the disclosure of research participants’ religious and spiritual beliefs, wherein they have a right to retain their privacy.</li><li>• The application procedure for a Category 3: Medium Risk research study was followed in accordance to Table 4.1 of the Standard Operating Procedures for Research Ethics Risk Assessment document from UNISA</li><li>• This research study met all the necessary specifications for Category 3 research and was given ethical clearance by the UNISA Department of Psychology research ethics committee.</li><li>• The participants were interviewed in a setting of their choice to further minimise the participants’ discomfort or inconvenience. The participants</li></ul>
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	<p>were offered debriefing and counselling sessions with an independent psychologist immediately following the interview. The researcher then contacted the participants via email two to three weeks after the interview to ensure that they had not experienced any adverse effects from their involvement in the research. Counselling was offered in this email as well. No participants reported any psychological discomfort or harm.</p> <ul style="list-style-type: none"> <li>- The researcher informed the participants that there is no time limit in which they need to request counselling and they may revert back to the researcher to request this service at any time.</li> <li>- The benefits of this research were judged to outweigh the potential risks.</li> <li>- The benefits of the research that were reported by the participants included some of the following:             <ul style="list-style-type: none"> <li>• Pastors reported relief at being able to discuss their experiences.</li> <li>• Pastors expressed gratitude for the information that they had received about mental health during the interview. This information was verbally</li> </ul> </li> </ul>
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	<p>provided by the researcher when the pastors requested it, for example, a pastor who asked what depression is, was given an answer during the interview.</p> <ul style="list-style-type: none"> <li>• Pastors were expectant of the outcome of this research, because they desired further collaboration between the disciplines of pastoral ministry and mental health.</li> <li>• The psychologists reported that the interviews had given them the opportunity to apply critical thinking to the interface of religion, spirituality and mental health.</li> <li>• The psychologists further commented that the research topic was an interesting one and that it needed to influence the landscape of Psychology in South Africa.</li> <li>• The desire for greater levels of collaboration between the two disciplines was also expressed by the psychologists as an anticipated outcome of the research study.</li> </ul>
<p><i>4.1.2. The principle of respect for persons:</i>  <b>The principle of autonomy:</b> Participants who are capable of deliberation about personal choices should be treated with</p>	<p>- Participants were given full autonomy and were treated with respect at all times. They were able to withdraw from the research at any time.</p>

<p>respect for their capacity of self-determination and be afforded the opportunity to make informed decisions with regard to their participation in research. Therefore there must be special protections for those with diminished or impaired autonomy for example, dependant and or vulnerable participants need to be afforded safeguards against harm or abuse.</p>	<ul style="list-style-type: none"> <li>- There were no participants in this study who had impaired or diminished autonomy.</li> </ul>
<p><b>The principle of confidentiality:</b> A participant's right to both privacy and confidentiality must be protected. The researcher must ensure that where personal information about research participants or a community is collected, stored, used or destroyed, this is done in ways that respect the privacy or confidentiality of participants or the community and any agreements made with the participants or the community.</p>	<ul style="list-style-type: none"> <li>- Some of the participants who were interviewed reiterated their desire to remain anonymous and for their confidentiality to be protected. For this reason, the participants were numbered and lettered at various junctions in the findings and discussions chapter so that their confidentiality could not be compromised. As mentioned, data extracts that contained identifying information were modified to protect confidentiality.</li> <li>- The raw data were transcribed and coded with lettering or alphabetical codes so that anonymity was protected</li> <li>- The data will not be destroyed for the purpose of further research potential which was included in the participants' informed consent.</li> </ul>
<p><i>4.1.3. The principle of justice</i> Justice imposes an ethical obligation to treat each person in accordance with what is right and proper. In research this is primarily</p>	<ul style="list-style-type: none"> <li>- All participants were treated with respect in this study.</li> <li>- The researcher believes that this study will bring benefit to the participants in</li> </ul>

<p>distributive justice whereby there should be equitable distribution of both the burdens and benefits of research participation. It is an ethical imperative that the study should leave the participant and or community better off or no worse off.....(full quote available on p. 3)</p>	<p>the continual constitutional right for freedom of religion to be respected. The findings and discussions chapters of this study were forwarded to every participant, if they so consented, so that the findings could be implemented where desired.</p>
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- ***Acting in the Best Interest of the Research Participant (p. 3 -5)***

The best interests of the research participants were at the forefront of the methodology underpinning this study. Their well-being, health, dignity, privacy and trust were protected, and the researcher did not abuse her potential position of power when collecting the data. The risks of the research were carefully reviewed, and the participants had numerous opportunities to withdraw from the study, or withdraw informed consent, even after their interview had been conducted. The researcher was available to the participants at all times through email and telephonic contact, and they were not offered any undue inducements for their participation in the study. There were no direct expenses incurred by the participants, however, the researcher made it clear that any unforeseen expenses would be covered. There was no payment given for participation, but the researcher did give each participant a small token of thanks (chocolate or biltong) to acknowledge their participation.

- ***Informed Consent: (p. 5 – 6)***

Potential participants were initially contacted via email with a basic overview of what the research entailed. They were asked to reply in the affirmative if they were willing to take part in the study, at which time more detailed information would be sent to them. When participants replied in the affirmative, they received a more detailed email containing the rationale for the study and the basic question protocol that would be given to them. The participants were also given the ethics committee letter of endorsement as an attachment to the email. Once the participants had received this second correspondence, they were given the opportunity to decline participation. When accepting participation, the researcher emailed them a third time in order to confirm a time and date for the interview, which they chose according to their availability. Before the interview took place, the researcher confirmed their participation via email and invited them to ask any questions or raise any concerns that they

had. At the interview itself, the participants were asked to read an informed consent document which outlined the research procedure, including the transcription and method for analysis and reporting of the data. Before the interview commenced, the researcher explained the rationale for the study, once again, and welcomed any questions or queries. While writing the chapters for the thesis and reviewing the data, the participants were emailed again to ensure that their informed consent remained in place, and to ask them to provide the researcher with some outstanding biographical data; this formed part of an ongoing process of obtaining informed consent while ensuring confidentiality and anonymity (Babbie, 2005). Not all of the participants responded to this last correspondence, but the researcher remained confident that all protocols for informed consent had been followed in accordance to ethical guidelines.

- *Conflicts of Interest: (p. 7)*

There were no direct conflicts of interest present for the researcher or the participants. It must be reiterated, however, that snowball sampling was the method of participant selection, and therefore four of the participants had a pre-existing professional relationship with the researcher. This professional relationship was not determined to be a conflict of interest by the researcher, the participants, or the supervisors of this study. Rather, it appeared to make the participants feel more comfortable in discussing a potentially contentious subject. None-the-less, the fact that the researcher was known to some of the participants was a consideration in how the data were both collected and analysed. The researcher had to be vigilant in not making assumptions about the meaning that participants attributed to the reported experiences; this was facilitated through the researcher's continual reflective questioning throughout the interview, for example:

If I understand you correctly.....

Are you saying or implying that.....

Am I correct in understanding that your experience was one in which.....

These questions gave the participants frequent junctures at which they could clarify and extrapolate on the meanings and experiences they had so that the researcher carefully documented each account given. When the data were analysed, the analysis focused purely on the basis of the meanings described by the participants, and the memo notes that the researcher had taken during the interviews to further describe the participants' responses.

Furthermore, the possibility existed that the researcher and participants would encounter one another after the interviews within both personal and professional contexts. This eventuality was discussed verbally with the participants and the researcher undertook to protect the anonymity and confidentiality of all the participants indefinitely. The researcher also stipulated that the identity of the research participants would not be divulged to other research participants. The participants understood these considerations and willingly partook in the research despite these extraneous factors.

### **Researcher Stance**

Hammersley and Traianou (2012), remind qualitative researchers that ethical considerations must include the researcher's response to criticism about the research itself. By means of ensuring the highest standards of research were being followed, the researcher presented the pilot study results at four conferences. The first conference, 2<sup>nd</sup> Biannual Conference for Spirituality and Health (October, 2016) was chaired by Professor Christina Puchalski, a renowned researcher in the area of Spirituality and Health from the George Washington Institute for Spirituality and Healthcare (GWISH), in The United States of America. This conference was attended by medical, health, and theology professionals. The second conference was the World Psychiatric Association Congress (November, 2016). This conference was attended by psychiatrists, psychologists, and other allied health professionals from a myriad of countries. In June 2017, the same results were presented at the Grace Christian Counselling Conference in Durban, attended by medical, health, and theology professionals. This conference was then repeated in Pretoria in August 2017 where the audience also contained medical, health, and theology professionals. The feedback received at these conferences about the research design/methodological/findings was used to make the necessary modifications and adjustments before the main data collection phase ensued. Furthermore, the results of the pilot study were published in *Proceeds of the 2<sup>nd</sup> Biannual South African Conference on Spirituality and Healthcare*, a peer-reviewed publication. Suggestions made by the review and editing panel for the journal during the consideration of the publication were similarly incorporated into the research before it continued to main data collection. In 2018, the preliminary research findings were presented at the PsySSA's (Psychological Society of South Africa) Mamele Conference in September 2018, and the Spirituality, Theology, and Education Conference at UNISA, September 2018. Feedback from those presentations was

used to consider the validity of the research findings and the discussion thereof. The supervisors for this study were constantly updated on the research process and provided with field notes, preliminary findings, chapter drafts, and final conclusions. Their feedback was integral to the amendments made throughout the study.

The researcher was, therefore, open to criticism and to required modifications for the study throughout the research process.

### **Section Ten: Conclusion**

The exploratory and descriptive nature of this qualitative research study required that my ontological and epistemological positions be carefully reviewed for the sake of transparency. My life history, beliefs, values and experiences have formed my existential reality and paved the rationale for the design of this study, which is why researcher reflexivity has been provided throughout this thesis. Due to the interpretivist nature of the research, the meaning and perceptions that the participants communicated took centre stage in the analysis of the data. Both manifest and latent meanings were meticulously reviewed in order to form thematic networks and themes to give expression to the participants' realities. Through the research process, knowledge was constructed within the interactions that took place between me and the participants, this co-created knowledge led to the emergence of "in vivo codes" ("two worlds" and "unnamed conflict" that formed an integral foundation upon which the research findings were established. This research has demonstrated both exploratory and descriptive qualities; it has explored a subject that has not yet been explored within the South African context, and through this exploration, the research has been able to give voice and description to the subject, to the "unnamed conflict" that occurs between the "two worlds" of pastoral ministry and psychology.

**CHAPTER THREE**

**THEORETICAL POINT OF DEPARTURE**

**Section One: Chapter Introduction and Outline**

**Section Two: Secularism and Post-Secularism: A Brief Summary**

**Section Three: The Biopsychosocial-Spiritual Model of Healthcare**

The Applicability of the Biopsychosocial-Spiritual Model for a South African Context

**Section Four: Conclusion**

## **Section One: Chapter Introduction and Outline**

As outlined in Chapters One and Two, this study aimed to examine the interface of religion, spirituality and mental health from the perspective of both pastors and psychologists. With religion and spirituality being one of the main foci of the study, it was necessary to establish how perceptions of religion and spirituality have been formed, and how they have changed over time. Theories of secularism and post-secularism provided a context for the understanding of these perceptions. Publications that considered the impact of secularism and post-secularism on healthcare sectors similarly provided valuable information that was relevant to this study. Therefore, these theories were used to hypothesise possible interpretations for the data.

This chapter begins with a brief summary of the main tenets outlining secularism and post-secularism that were applicable to this study, the summary is by no means an exhaustive or comprehensive one though, because it only contains an outline of secularism and post-secularism pertinent to this study. Following that section is a review of a few sources that consider the impact of secularism and post-secularism on the healthcare sector. The biopsychosocial-spiritual model is then paralleled to the influence of post-secularism on the development of healthcare models and is suggested as a plausible model for the South African context.

## **Section Two: Secularism and Post-Secularism: A Brief Summary**

Lombaard, Benson, and Otto (2018) recently again reviewed the role that religion has played in society, starting with its pre-modern existence where religion was dominant and filled much of the private and public sphere of peoples' lives; followed by the shift to democratic political structures where religion was side-lined to the private realm of individuals' lives with a silencing of its public authority. With the shift towards modernity in the Western world, the foundational influence of philosophical thinkers such as Feuerbach, Marx, Nietzsche, Weber, Durkheim and Freud must be considered (Lombaard, 2016). These voices of modernism hypothesised that religion would lose its value and function in society, which would relegate it to a historical construct with little bearing on modern discourse. As much as that may have been the political agenda of a modern and secularised society, Habermas (2008) and Lombaard et al. (2018) both ask whether or not religion has remained in this sequestered position, or if its pertinence has begun to re-emerge.

When reviewing the secularisation of society, Van der Veer (2014) traces the roots of secularism to the term used by George Holyoake in 1846, where he referred to Christianity as being “irrelevant speculation” (Van der Veer, 2014, p. 170) which impacted the development of secular societies that were formed in the 1850s. Van der Veer (2014) states that these early secular societies held anti-church and anti-establishment attitudes that sought to experiment with and produce scientific knowledge that was not necessarily legitimised by religious institutions. The progress of science and the defining of spirituality was separated and distinguished from religion, or the influence of the church. The move towards enlightenment was translated in modernisation and secularisation as the pursuit of verifiable, naturalistic and observable knowledge, which was understood as being devoid of religious foundations or speculation (Brissett, 2006). As Watson (2015) summarises, knowledge was based on principles that were observable in the natural world, and separated from religious affiliation or belief. In this way, as Lombaard et al. (2018, p.6) summarise:

Wherever Western technology accompanied by Western thinking succeeded, on all the continents of the world, their religious heritages therefore lost their power and societal influence, in the process called secularisation.

Therefore, by means of defining the primary connotations of secularisation Casanova (2006) defines secularisation in three main ways:

1. Secularisation as the decline of religious beliefs and practices among individuals within society;
2. Secularisation as the privatisation of religion: religious expression and religious influence is seen to be a function of an individual’s personal, private life, rather than it finding expression or gaining momentum in public arenas of society; and
3. Secularisation as the differentiation of the secular spheres: this is the separation of the state, the economy and science from the influence of religion and religious institutions.

Casanova's (2006) definition of secularisation overlaps with that of Stammers and Bullivant (2014). Stammers and Bullivant (2014) use the term secularism to refer to two main concepts, the first being the socio-cultural meaning of secularism, in which there is a lack of belief in and practices associated with religion in a specific society. The second concept of secularism considers the political and philosophical doctrines regarding religion and its centrality in the public sphere. This is similar to the decline of religious beliefs, and the differentiation of secular spheres referred to by Casanova (2006). In these definitions, the prevailing themes are the decrease of religion in the public realm and the separation of church and state. As Bustamante (2014) points out, this separation of church and state creates a society where religious rituals and references to religion become increasingly meaningless and extraneous. Instead, individuals are dissuaded from understanding social and political relationships from within a religious framework, and are urged to develop shared language that is purported to be neutral through its relinquishing of overt religious positions. As Lombaard (2016) illustrates, there have been two movements in society in relation to the place of religion, one of them being the "Big Yes" and the other being the "Big No". The "Big No" was evidenced by modern and post-modern eras being ones that said "No" to religion in order to facilitate greater levels of human maturity. The "Yes" associated with more pre-modernism and post-secular society where religion and the re-emergence thereof, respectively, is given more credence within the public sphere.

Although Watson (2015) acknowledges the various ways that religious expression or doctrine may, at times, have been detrimental or oppressive in society, he calls for a re-evaluation of the assumption that secularisation is a prerequisite for a democratic state. The consequences of an insistence on secularisation are consequences that Watson (2015) argues to be detrimental to society at large, and to individuals. A side-lining, rejection, antagonism towards or marginalisation of religious expression is fundamentally an infringement on one's right to freedom of religion. Rather, for a society to be truly democratic, there ought to be an intrinsic respect and protection of individuals' personal integrity, which is not necessarily optimally achieved through the privatisation of religion (Watson, 2015).

In an interview with Peter Berger, Mathewes (2006) inquires about Berger's advocating of a theory of secularisation which was later followed by his renunciation of that same theory. Berger makes the point that evidence has shown him that modernisation does not necessarily correlate directly with secularisation, certainly not in all societies. This is because modernity gives rise to pluralism in society, a pluralism of worldviews, of value systems and of beliefs.

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Sometimes, these worldviews, values and beliefs are interwoven with religious ones, and at other times, the worldviews are independent of religious influence. Nonetheless, pluralism, by its very nature, makes the choice of integrating religion available to individuals. To assert secularisation, therefore, would be contentious if it required that someone choose against their religious preferences. In this way, Berger (as cited in Mathewes, 2006) states that religion should no longer be marginalised as being insignificant in sociological theory, but rather that religion contributes to sociological theory and to the understanding of mankind.

When it comes to the “Big No” previously mentioned (Lombaard, 2016), it is suggested by Spencer (2003) that the Social Sciences have been particularly complicit in the promotion of secularisation by supporting the theory that religious decline allows for societal progress, and that a causal relationship exists of societal progress being advanced only in the absence of religious influence. The underlying assumption for those who support secularisation, therefore, is that human maturity is best reached through a separation from religion (Lombaard, 2016). This has caused a polarisation of social scientists into two main positions when it comes to the theory of secularisation: there are social scientists who want to dispose of the theory completely, and then there are social scientists who want to retain certain components of the theory for a specific use or purpose (Spencer, 2003). Instead of allowing for polarisation to occur between these two positions, Geddes (2006) argues that it is more helpful to ask questions around what religion is, what role it plays in a pluralistic society, and where the place of religion is in societies. With these types of questions or arguments coming to the fore, the relevance and usefulness of secularisation comes under scrutiny.

As mentioned in Chapter One, the shift from secularism to a more post-secularist society is evidenced by an increased awareness of the influence that religion and religious institutions continue to have on citizens (Habermas, 2008). Habermas (2008) argues that this may be due to emerging post-secular trends in society. Although secularism may have created religions loss of public influence, it did not eradicate the salience of religion in the general culture of society. There is an increased awareness and consciousness of religion in society even within a secularised society, which Habermas (2008) attributes to three primary processes. The first one is the fact that there are many international religious conflicts that increase the awareness of religious fundamentalism in society, for example, terrorism. Secondly, religion is regaining its impact in the public spheres of society by becoming “communities of interpretation” and making contributions to significant value-laden societal issues such as abortion (Habermas, 2008, p. 20). Lastly, Habermas (2008) states that the resurgence of

immigrants in Europe has resulted in a pluralistic multicultural society in which tolerance for divergent worldviews, cultures and religious or spiritual traditions is a necessity. This means that religion exerts an undeniable influence within a seemingly secularised society, which leads to a post-secular society where religion has not been obliterated, but functions within a pluralistic culture. With this post-secular trend, the re-emergence of religion within the public realm is becoming more evident (Hill et al., 2000), which implies the necessity for tolerance and respect for differences in a society that is increasingly more multicultural and diverse. Although the term “spirituality” is seen more favourably than religion in the post-secular religio-cultural societal context, the fact remains that an acknowledgement of finding meaningful experience in being religious or spiritual is becoming more normative (Lombaard et al., 2018). As Lombaard (2016, p. 4) states, “the view of liberty as the exclusion of religion from public life is becoming increasingly questioned”.

Ferngren (2014) reviews how secularisation has entered almost all spheres of public society, including healthcare systems and the training of physicians, with the resulting impact of any religious emphasis being distanced from medical training. With this distancing came a preferred naturalistic model of science, medicine and healthcare. Ferngren (2014) posits that the more naturalistic model of healthcare was one in which spiritual values were relegated to redundancy, which diminished the focus on vocational calling and compassionate care. With the resurgence of the importance of religious and spiritual influence within a post-secular society, the implications thereof are extensive. Through the shift to a more post-secularist society as described by Habermas (2008), the way has been paved for models of healthcare to respond accordingly, by considering the impact of religion and spirituality on models of healthcare. Both Puchalski (1999, 2014) and Sulmasy (2006) have contributed models of healthcare that consider religion and spirituality as critical components to whole-person care, which is discussed in more detail later in this chapter, and in Chapters One and Six.

With this re-emergence of religion in the public realm, it is becoming pivotal for healthcare professions to consider the influence of religious and spiritual factors. Until recently, the move of secularism seems to have impacted the way that mental health professionals integrate spirituality into their practice out of concern that religion and spirituality should be the private domain of the individual, and should not infiltrate scientific practice (Kahle & Robbins, 2004). Some mental health professionals were found to fear speaking about religious and spiritual beliefs, because they deemed it to be unethical (Miller, 2003). Miller (2003) further notes that healthcare practitioners in the United States responded to the separation of

church and state by feeling a sense of apprehension and awkwardness in discussing religious and spiritual topics with their patients. Therefore, the practitioners avoid the discussion of spiritual matters, and do not inquire or assess the impact of religious and spiritual beliefs when working in secular institutions, lest it be construed as a contravention of the separation of church and state. Biggar (2015) concedes that within the profession of medicine and other health professions, there has been a secularisation of religion and spirituality in an attempt to banish the “irrational” from the “rational” space of science. However, Biggar (2015, p. 233) argues the following in response to this secularised position:

I have argued that medicine should be considered “secular”, not in the secularist sense of being religion-free, but in the Augustinian sense of being a forum for the negotiation of rival metaphysical and ethical views. I have argued that religion deserves a place at the secular table of negotiation, because it is not simply or invariably or uniquely irrational.

When considering the separation of church and state, and the secularisation of society, Kahle and Robbins (2004, p. 30) ask a pivotal question:

Would talking about God in therapy, even in a state agency, constitute a violation of the laws related to the separation of church and state?

In answering this question, Kahle and Robbins (2004) posit that speaking about one’s faith or beliefs does not constitute a “church activity”, and that it is not a contravention of any law to discuss these dimensions of one’s reality. In fact, freedom of religion allows a person to possess those beliefs and to express them without fear of prejudice or discrimination. However, with an increasing acceptance by the field of Psychology that religion and spirituality are components of a person’s culture, the field must respond by carefully reviewing an ethical framework in which these constructs of religion and spirituality can be explored (Kahle and Robbins, 2004).

If the fields of Psychology and Medicine are cognisant of the role that religious and spiritual beliefs may have for patients, then an argument should be made for the ethical integration thereof. In line with that argument, Baumann and Pajonk (2014) review the

multitude of ways that a patient or client's religious and spiritual views are irrefutably interwoven with mental health. This includes findings such as:

- The interpretation of mental health symptoms and the possible treatment thereof is mitigated by religious considerations;
- The stigmatisation that is attached to mental illness or to mental illness sufferers is less hostile in people with strong spiritual beliefs;
- The availability of coping strategies as well as adherence to treatment is affected by clients' beliefs; and
- Spiritual and religious beliefs impact positively on quality of life and general well-being, even when mental health is compromised.

For religion to be re-afforded its standing in the secularised public sphere of society, including the arena of healthcare, the above factors imply that both legal and political frameworks have to allow for religion to hold a position in which it is not privileged, as it would have been in pre-modernism, nor disadvantaged, as would have been the case in modernism (Lombaard, 2016). Rather, it becomes necessary for spirituality and religion to be considered as constructs worthy of evaluation and integration in a holistic review of the human condition. To this end, Habermas (2008) emphasises the necessity for tolerance to permeate societies within a post-secular climate. This tolerance would allow for believers of a specific faith, believers of other faiths, and non-believers to afford one another the basic right to adhere to belief systems and practices of their choosing, even if those beliefs differ from their own. This would produce an inclusivity in society that is dependent not on religious or spiritual affiliation, but rather on the principle of equal citizenship and individual rights.

As Biggar (2015) states, the discussion of religion in healthcare is a discussion around ethics, and the assumption that healthcare models should be secular, empirical models, that negate the influence of religion is a contentious assumption. This is captured in the following statement by Biggar (2015, p. 229):

Unbelievers, of course, doubt that religion commands sufficient reason. But believers beg to differ.

Therefore, the trademark of an ethical healthcare model should be one that prioritizes the equal dignity of all people, individual autonomy, and an unequivocal commitment to the well-being of those people.

In response to the argument of secularism and post-secularism as set out in this chapter, the indispensability of a healthcare model that gives credence to religious and spiritual factors is accentuated. As mentioned briefly in Chapter One, the biopsychosocial-spiritual model is a model of healthcare that considers these constructs, and will be outlined below as a means of illustrating a more post-secularist perspective.

### **Section Three: The Biopsychosocial-Spiritual Model of Healthcare**

The biopsychosocial-spiritual model developed from the biopsychosocial model of healthcare which was proposed by George Engel as a rebuttal to the biomedical model of healthcare (Engel, 1977). In the light of research at the time, demonstrating the impact of psychological stressors on physiological processes, Engel (1977) saw the biomedical model as being reductionist and posited a medical model which was more ethnomedical. An ethnomedical model would provide a more scientifically holistic approach to the understanding of disease and health. One of the central tenets of this ethnomedical model would be the consideration of psychological and social factors in forming an understanding of the disease or the symptoms presented. Furthermore, Engel (1977) specified the salience of the physician-patient relationship in determining factors such as patient compliance and patient recovery, which should be taken into account with a new model of healthcare. Engel (1977, p. 132) makes the following statement in advocating a biopsychosocial model versus a biomedical model:

The existing biomedical model does not suffice. To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of healthcare, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model.

Therefore, the biopsychosocial model demonstrates the argument that the boundary between health, disease and wellness is not always a clearly defined one, due to the fact that

the boundary is extensively influenced by cultural, psychological, and social factors. In order to understand health, disease, and wellness, a holistic conceptualisation of these dimensions is paramount (Engel, 1977). It is with a model such as this that the humanity of patients becomes more of a focus when compared to the biomedical model, which is often experienced as being overly clinical and impersonal, with an accompanying disinterest or insensitivity perpetuated by medical staff. The biopsychosocial model was, therefore, suggested by Engel (1997, p. 135) to be a model that veers away from the biomedical tradition and provides a “blueprint for research, a framework for teaching, and a design for action in the real world of healthcare”.

Engel (1980) went on to add that practitioners who are trained in the biomedical model often make their decisions about treatment, which impacts a patient’s interpersonal and social spheres, on very little information about that patient’s holistic functioning. However, practitioners who base their decisions within the framework of a biopsychosocial model are keenly aware of the patient’s social environment, and how treatment may destabilise those realms. Engel (1980) posits, therefore, that the biopsychosocial model is a scientific model of healthcare that addresses areas neglected by the biomedical model.

King (2000) reviewed the necessity for a biopsychosocial model in healthcare, but added that the dimension of spirituality or religion is of equal significance as the psychological and social realms. King (2000) recognised that research was increasingly proving the importance of religion and spirituality on medical or health outcomes. With a plethora of research providing a positive correlation between religion, spirituality and health, King (2000) found the biopsychosocial model lacking in its consideration of a patient’s religious or spiritual beliefs. McWhinney (1983) as cited in King (2000) stated that the specialisation of family medicine should incorporate the issues of disease prevention, a patient’s environment, communication, the meaning of the illness for the patient, and an integration of a patient’s body, mind and spirit into their treatment of patients. With this exhortation in mind, King (2000) advanced their call for a biopsychosocial-spiritual model to be developed. As substantiation for the call to consider a biopsychosocial-spiritual model, King (2000) cited numerous research initiatives that included findings such as:

- Religious and spiritual well-being is correlated with lower levels of reported anxiety, depression and suicidal ideation;
- Religious involvement is positively associated with life satisfaction and well-being;

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- Substance abuse is mitigated by religious or spiritual involvement;
- Some religious beliefs can be linked to poorer mental health outcomes, particularly beliefs that God is punitive or punishing;
- Extrinsic religious commitment for example, when based on social gain or external authority, is also correlated to adverse mental health;
- Religious involvement is related to better physical health;
- Religion and spirituality practices are used as a form of coping in patients being treated for anxiety and depression; and
- The majority of patients (in that specific study cited as King and Bushwick, 1994) have a self-reported desire for healthcare practitioners to address their religious and spiritual needs in the course of diagnosis or treatment, but also reported that the majority of them had not had that type of experience with their physicians.

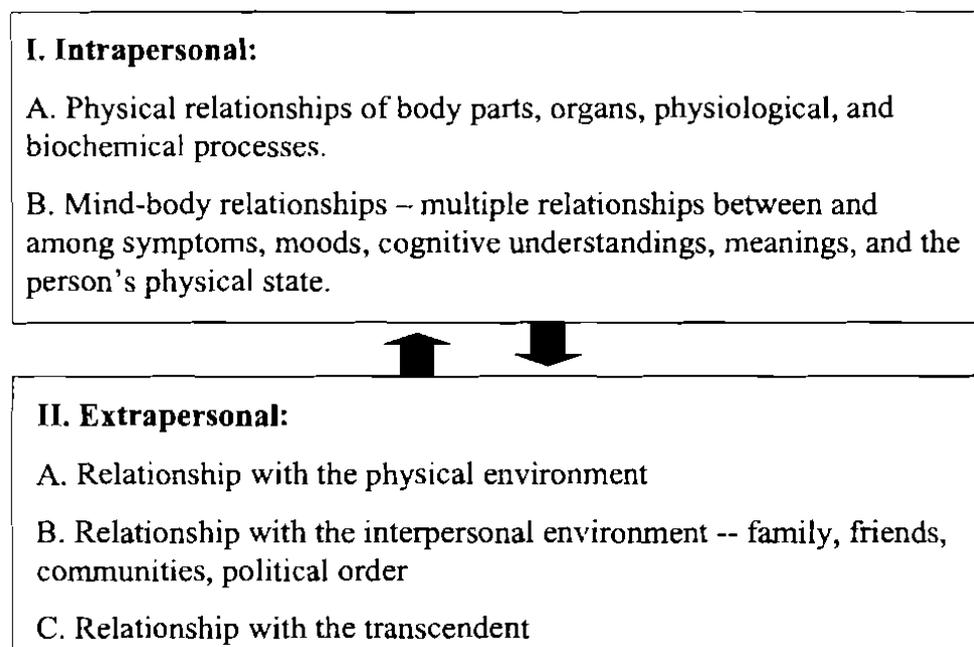
On the basis of the above research (the references of which are available in King 2000), a biopsychosocial-spiritual model is suggested by King (2000), in which the following factors should form part of an intentional consideration by healthcare practitioners in the assessment, diagnosis and treatment of patients:

- The inclusion of spirituality and religion that reviews a patient's belief in God, nature, or inner self as well as other cultural or spiritual beliefs that give meaning to a patient's life or worldview;
- The consideration of the patient's religious or spiritual practices for example, prayer, and how this impacts on their understanding of health, or their preferred treatment foci;
- A standardised practice of screening a patient's spiritual history routinely as part of a medical examination;
- The acknowledgement of a patient's spiritual needs and the referral of patients for spiritual counselling if required, or if requested;
- An understanding by the practitioner that spiritual and religious beliefs undergird a patient's existential interpretation of the world, as well as their health and illness. Religious and spiritual beliefs form a system, a worldview, which is involved in how patients make sense of life events, and as such, must be interwoven with how practitioners respond to those events;

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- An acceptance, by practitioners, that the inclusion of religious and spiritual beliefs in healthcare should not be seen as an addendum to the traditional biopsychosocial model, but rather, it should be seen as a factor that permeates biological, psychological and social processes; and
- The biopsychosocial-spiritual model is one that provides an opportunity for the doctor-patient relationship to be a more effective one in that it fosters a depth of understanding for the patient and therefore can better meet the needs of that patient.

In response to the call from King (2000) for a biopsychosocial-spiritual model, Sulmasy (2002) expanded this model by noting that King (2000) had not specifically considered or provided the “philosophical anthropological” (Sulmasy, 2002, p. 25) foundations of such a model, or the effective integration thereof into the prevailing culture of patient reductionism. The philosophical anthropological position asserted by Sulmasy (2002) is that human beings are, by their very nature, intrinsically spiritual beings, because of the fact that they are beings who are in relationships. The relationships that are inherent in a human being’s life are divided by Sulmasy (2002) into two primary spheres, intrapersonal and extrapersonal. The nature of these spheres, and the interplay between the two spheres, is depicted in the figure below (Sulmasy, 2002, p. 26):



*Figure 2: The Intrapersonal and Extrapersonal Spheres of the Biopsychosocial Model of Healthcare, Sulmasy (2002, p.26).*

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Based on the figure above, Sulmasy (2002) asserts that illness disrupts relationships in both the intrapersonal and extrapersonal realms. Illness does not only impact the intrapersonal sphere of body parts, organs and physiological processes, but it also impacts family relationships, work productivity, methods of coping, and perceptions of the transcendent. In this way, the intra- and extrapersonal realms are in constant interaction, impacting one another consistently. Sulmasy (2002) therefore posits that the notion of healing should not be confined to the healing of physiological processes, or healing of the “whole” person, but rather, healing should be understood as “in its most basic sense, means the restoration of right relationships” (Sulmasy, 2002, p. 26). Healing, therefore, can take place in the physical parts of a patient’s body, but that is only one dimension of healing, because healing in other relationships is of equal value. This is particularly prevalent in end-of-life treatment, where it is possible that a patient’s intrapersonal symptomology may no longer be curable, but an emphasis on other relationships can provide a poignant point of extrapersonal healing. In order to achieve this approach to holistic healing, it is a basic requirement that a practitioner at least inquires about a patient’s spiritual and religious beliefs, and if found to be of no significance to the patient, the practitioner can proceed without an integration of the patient’s beliefs. According to Sulmasy’s (2002) model, every human being is understood to have a spiritual history; for some that includes religious and spiritual beliefs or traditions, and for others it does not. The fact remains, though, that the model stipulates that human beings possess physiological, psychological, social and spiritual dimensions, none of which can be separated from the “whole” of a person.

In considering the spiritual dimension of a patient, Sulmasy (2002) suggests that religion and spirituality is measured according to four main dimensions: religiosity, spiritual/religious coping and support, spiritual well-being, and spiritual needs. Through an analysis of these dimensions, Sulmasy (2002) posits that the healthcare practitioner will gain insight into how the patient will interpret his or her illness, and the appropriate holistic treatment that the patient requires. The biopsychosocial-spiritual model is therefore purported to contextualise the patient as a being-in-relationship with both intra- and extrapersonal factors which all influence their holistic well-being. As Sulmasy states (2002, p. 24):

Therefore, genuinely holistic health care must address the totality of the patient's relational existence - physical, psychological, social, and spiritual.

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Sulmasy (2006) reiterates in a later publication reviewing the biopsychosocial-spiritual model, that the spiritual state of a person can be moderated by the biopsychosocial functioning, and that the spiritual state can also be a moderator of the biopsychosocial realm. Therefore, the healthcare practitioner should constantly be aware of the interplay between these four dimensions, and should be compassionately attuned to the patient. Through this compassionate awareness, the practitioner can create a relationship wherein the patient feels comfortable to express and work through the spiritual concerns that he or she may have. The practitioners should also pay close attention to their own spiritual histories and experiences, because this may impact how they deal with the spiritual dimension of their patients (Sulmasy, 2006).

Cobb et al. (2014) suggest that practitioners be aware of assessing a patient's spiritual or religious needs and that they recognise that all patients, even those of no religious faith, should be afforded the opportunity to explore their religious and spiritual needs. This can be achieved through:

- Exploring the patient's sense of meaning and purpose in life;
- Exploring the attitudes, beliefs, values and concerns that the patient may have regarding life, death, and dying;
- Affirming a patient's life and their worth by encouraging them to reminisce about the past; and
- Exploring the patient's hopes and fears about their present and their future, including those of their families, significant others, or carers, and by asking the "why" questions about life, death, and suffering.

The above guidelines for the assessment of spiritual and religious needs are reflective of Puchalski's (2001) call for the science of Medicine to shift from reductionist methods of understanding patients to a holistic perspective. This holistic approach would encompass the patient and the patient's family as equal contributors in the decision-making process of treatment and care. Puchalski (2001, p. 1225) captures the essence of how Medicine should shift with the following statement:

The patient brings his or her experiences, beliefs, and values to the clinical setting as well. So decisions are made in a complex context utilizing scientific data, the physician's experience, and the experiences, preferences, beliefs, and values of the patient and his or her family. This process cannot be distilled into

a simple mathematical decision tree. Medicine is far more than a science. It is also an art and, consequently, requires more than the scientific method.

In a later publication by Vitillo, Puchalski, Hull, and Reller (2014), the above statement is recapitulated through a justification for the use of the biopsychosocial-spiritual model in healthcare spheres. This would promote the compassionate care of patients, and would enable healthcare practitioners to be attuned to the complex system of biological, psychological, social and spiritual aspects in which the patient exists.

Cobb et al. (2014) reiterate that a biopsychosocial-spiritual model of care is a valuable theoretical framework that encompasses the requirement for practitioners to be knowledgeable about the interplay of these dimensions. Saad, De Medeiros, and Mosini (2017) agree that this model is beneficial to the holistic and humanistic conceptualisations of suffering, illness, disease, and wellness. The shift in healthcare from reductionist methods to the movements of humanisation (patient-centred care) and personalisation (person-centred care) has placed the clinical significance of spirituality at the forefront of healthcare. However, the term “spirituality” is a fluid one with infinite definitions and interpretations, which results in varying conceptualisations thereof. As Saad et al. (2017, p. 5) aptly state:

A true paradigm shift will occur only when the human spiritual dimension is fully understood and incorporated in health care. Then, one will be able to cut stereotypes and properly use the term “biopsychosocial–spiritual model”. A sincere and profound application of this new view of the human being would bring remarkable transformations to the concepts of health, disease, treatment, and cure.

### **The Applicability of the Biopsychosocial-Spiritual Model for a South African Context**

Considering that this study makes the South African context a critical point for consideration, one must ask the question on the applicability of the biopsychosocial-spiritual model as a theoretical framework for understanding the findings of this study. To this end, I draw on the argument posited by Janse van Rensburg (2014) for the use of this model in mental healthcare for the South African context.

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As Janse van Rensburg (2014) states, the biopsychosocial model has been the primary model by which medical practitioners have been trained for the assessment and treatment of patients. However, having acknowledged that South Africa is a multicultural and pluralistic society, the efficacy of the biopsychosocial model in capturing the nuances of existential, cultural meaningfulness is questionable. Along with the fact that South Africa is a multicultural and pluralistic society, Africa as a continent is reported to have the strongest, healthiest church and Pentecostal growth (Van der Merwe, 2015). Furthermore, in Africa, psychiatric and mental health care practice is often confronted with difficulties related to poverty, violence, suffering and death, which are intrinsically linked to existential and spiritual dynamics for patients (Janse van Rensburg, 2014). Considering these facts mentioned above, it is understandable that patients often bring these questions of meaningfulness to the fore when discussing symptomology with mental health practitioners, which requires practitioners to be able to respond in an appropriate and ethical manner. With research in culture, religion and spirituality growing, Janse van Rensburg (2014) suggests that research funding be made accessible for studies that review the influence of individuals' worldviews on treatment compliance, so that mental health policy and guidelines concerning training and practice can respond appropriately. One of the ways to refine mental health practice in South Africa is by using the biopsychosocial-spiritual model as a framework for effective assessment, diagnosis and treatment. To incorporate this, Janse van Rensburg (2014, p. 136) suggests the following practice guidelines for the profession of Psychiatry:

- Integrating defined spirituality in clinical care and in-service provision and use, by practitioners and patients, in their own lives and professional practice;
- Integrating defined spirituality in the training of local undergraduate and postgraduate students in psychiatry;
- Ethical integration of defined spirituality within the professional scope of practice; and
- Appropriate referral of patients and collaboration between psychiatrists and spiritual/religious advisors.

When reviewing the guidelines above, there is a correlation present between the extra- and intrapersonal relational factors that are posited by Sulmasy (2006). The integration of spirituality with clinical care and practice is, by definition, recognition of the relationship a patient has with the transcendent in their lives. By considering the role of spirituality in both

practitioners and patients, the practitioners become aware of their own, and the patients' extrapersonal dynamics. This is not separated from an analysis of intrapersonal factors that may be present in the physiological and mind-body spheres of a patient's clinical presentation.

Janse van Rensburg (2014) defines the use of a biopsychosocial-spiritual model as having specific ethical boundaries which must be applied within a professional's scope of practice. The use of this model is not an exhortation for practitioners to perform spiritual or religious acts to provide spiritual care as that would be the role of a spiritual advisor, or to impose their own spiritual and religious beliefs onto the patient. Rather, the incorporation of this model into healthcare practice is delineated as the intentional acknowledgment of spirituality, and how spirituality impacts on a holistic approach to healthcare outlined by the biopsychosocial-spiritual model.

Mthembu, Wegner and Roman (2016) echo the opinion that the consideration of spirituality and spiritual care be paramount in the training of professionals within the Health Sciences. In order to provide holistic patient care, as is the underlying ethos of the biopsychosocial-spiritual model, a consideration of the role of spirituality is mandatory. Mthembu et al. (2016) reflect that the majority of educators within the Health Sciences spheres are not efficiently equipped to provide the necessary training on the integration of spirituality into patient care. To this end, the authors provide detailed analyses of what such education should include, and encourage the South African tertiary education system to prioritise the integration of spirituality and spiritual care in training health professionals. It will only be through training that the biopsychosocial-spiritual model will become a viable healthcare structure within the South African context.

### **Section Four: Conclusion**

Having briefly reviewed secularism, post-secularism and the development of the biopsychosocial-spiritual model, I would like to conclude by interlinking these concepts.

As specified, secularism resulted in the privatisation and marginalisation of religion within the public realms of society. In turn, religion's influence on the political front was subdued in favour of pursuing verifiable knowledge, understood as knowledge that was devoid of religious influence. The separation of church and state permeated healthcare systems to the extent that religion and aspects of spirituality were silenced in professional practice. A

biomedical model was given preference, under the notion that it was founded on naturalistic and observable scientific data. The biomedical model, therefore, was one that reflected the principles of secularism in that it distanced itself from the consideration of religious and spiritual factors. With the realisation that a biomedical model was reductionist, the move towards considering psychological and social dimensions saw the development of the biopsychosocial model (Engel, 1977; 1980). Although this model allowed for psychological and social considerations, it still did not specifically allow for the inclusion of religious and spiritual beliefs.

As research grew, and society began to shift, the tenets of secularism began to be questioned. The privatisation and marginalisation of religion had to be re-evaluated in the light of the recognition that religion held value and influence for societal members. The move towards a more post-secular society as described, for instance, by Habermas (2008) had an impact on various sectors within society. One of these sectors was healthcare, which had previously been dominated by more secularised biomedical and biopsychosocial models. The resurgence of religion and the salience of spirituality gained momentum in healthcare, as was evidenced by the reassessment of the biopsychosocial model's efficacy for holistic patient care. The post-secular movement seems to have created space within which religion and spirituality could be recognised for its centrality in the lives of people, and the influence it thereby exerted on health, illness and disease. With that recognition came a proliferation of research related to the linkage of religion, spirituality and health. In response, the biopsychosocial model was deemed to be ineffective in capturing the interface of biological, social, psychological and spiritual realms, because of its failure to pay credence to religion and spirituality. The biopsychosocial-spiritual model was therefore formulated in order to recognise the previously neglected domains of the biomedical and the biopsychosocial models.

If one parallels the development of the biopsychosocial-spiritual model to the post-secular recognition of religion and spirituality, then the linkage between a societal or political shift can be seen as having found expression in the healthcare domain. Although there remains a nervousness and apprehension amongst healthcare professionals to merge overtly "church and state" in healthcare practice, the biopsychosocial-spiritual model at least offers a milieu in which post-secular religion-culture can be validated.

The discussion in this chapter will be interwoven with the findings of this study in Chapter Six, where I apply the impact of secular and post-secular movements to the findings

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of this study, to the perceptions of both the pastors and the psychologists. The biopsychosocial-spiritual model will then be incorporated as an embodiment of responses to secular and post-secular trends evidenced in the healthcare sector. Thematic analysis is the research method for this study, and so the themes and meanings that are identified in the data from the interviews will similarly be interpreted within the context of these secular and post-secular frameworks.

## CHAPTER FOUR

### FINDINGS: PASTORS

#### Introduction

In this chapter, I will review the dominant themes that were identified in the data analysis of the pastors' interviews. As will be shown in the Thematic Map in the conclusion section of this chapter, the four main themes and the categories within those themes are as follows:

#### **Theme One: Perceptions of Pastors towards Mental Health**

Category 1.1: Perceptions of the Validity of the Field of Mental Health as a Science  
(influenced by subcategories 1.1.1 – 1.1.3)

- Subcategory 1.1.1: Factors Influencing Perceptions: Training and Professional Development
- Subcategory 1.1.2: Factors Influencing Perceptions: The Opinions and Experiences of Leaders in Authority, Congregants, Community Members or Family Members
- Subcategory 1.1.3: Factors Influencing Perceptions: First-Hand Experience with the Field

Category 1.2: Fears and Concerns about the Field of Mental Health that Impact Their Perceptions

- Subcategory 1.2.1: Glorification of the Individual
  - 1.2.1.1: Glorification Through Self-Image
- Subcategory 1.2.2: Dependency and a “Functional Saviour”
- Subcategory 1.2.3: Labels, Lived Identity and the Abdication of Responsibility
- Subcategory 1.2.4: The Personhood and Role of the Professional
  - 1.2.4.1: The Pastors' Rationale of Healing

**Theme Two: Point of Departure of Pastors (Foundational Beliefs that Guide their Interpretations)**

**Theme Three: The Integration of Religion, Spirituality and Mental Health: “Two Worlds”**

Theme is described through three tables:

Table 16: The Role and Responsibility of the Pastor in ‘Bridging the Gap’

Table 17: The Role and Responsibility of the Psychologist in ‘Bridging the Gap’

Table 18: Shared Role and Responsibility of the Pastor and Psychologist

Conditions for the Referral from Pastors to Psychologists

**Theme Four: Stigmatisation**

Category 4.1.: Stigmatisation by Christians or Within the Church Context

Category 4.2: Stigmatisation that is Indigenously South African?

**Conclusion**

Thematic Map Discussion

Concluding Thoughts about Pastors’ Perceptions

Reflective Thoughts

The discussion of the identified themes will follow in Chapter Six where I will consider the findings of both the pastors and the psychologists, and draw conclusions from both sets of data.

### **Theme One: The Perceptions of Pastors Towards the Field of Mental Health**

There were many factors that influenced the pastors' perceptions of the field of mental health. These factors are discussed as subcategories, because each of them played a significant role in how the pastors' general perceptions were formed. This theme was the most complex and comprehensive of all the themes, because of the myriad of ways in which the pastors reported that their perceptions had been formed.

#### **Category 1.1: The Validity of the Field of Mental Health as a Science**

The perceptions of the field of mental health as a valid and legitimate science was a theme that each pastor either alluded to through latent meaning, or discussed directly with manifest meaning. The pastors' opinions were split as to the scientific validity of Psychology and Psychiatry. Not only was there divergence in the perceptions of the pastors; there was a similar disparity amongst the members of the leadership systems within which these pastors are embedded.

There were several factors that influenced their perceptions about scientific validity, including their personal experiences, the seminary training received, the opinions of leaders in positions of authority, and the experiences of congregants, community members, or family members.

Pastor B explained his concern about the science underpinning Psychology and Psychiatry with the following parallel:

*Interviewer: So, what do you feel about the Psychology, the science of Psychology, do you think it is a science or do you also not really think it is a science as much?*

*Pastor B: If I'm just brutally honest.....?*

*Interviewer: Yes, I want you to be brutally honest.*

*Pastor B: It feels to me like it's the chiropractic versus the "physiotherapy" of the mind and the emotion, so it is that controversy around, is the chiropractic a science or not? So yes.....*

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Pastor B paralleled the field of chiropractics to physiotherapy, the former being a “controversial” and debatable scientific discipline, and the latter being a legitimate, recognised scientific field. In this parallel, his implicit yet unarticulated opinion is that there is a greater level of respect for the fields that can be verified as scientific. This pastor was not convinced that the field of mental health can be classified in the same category as physiotherapy. The lack of scientific rigour that he perceives to be present in the field of mental health was expanded in the following statement:

*Pastor B: so it (psychology) is subjective, it's around your feelings, your experience...*

The realm of “subjective feelings and experience” is not a verifiable one, in this pastor’s mind, and if it is not verifiable, then it is not deemed to be scientific. Of interest, however, is the manner in which this pastor’s opinion about the field of mental health seemed to be ameliorated through the discussion that ensued between us. Towards the close of the interview he stated:

*Pastor B: Yes, I think it is an arrogant statement of mine to say that I'm questioning the integrity of the profession.....*

His self-perceived arrogance in questioning the scientific validity of the field was justified by recounting a personal experience with the psychologist who is currently treating a close family member. Based upon his outside perspective, this pastor had concluded that a particularly unhealthy dependence had formed, whereby his family member was not able to function optimally without the input of the psychologist. His resentment and frustration over this dynamic had infiltrated his reasoning about the validity of Psychology and Psychiatry as legitimate scientific fields. His self-reflection in this interview provided a context where he and I could openly discuss his perceptions, which led to him reviewing his opinion. As mentioned in Chapter Two, the fact that his perceptions shifted through the process of the interview illustrates the social constructivism of knowledge.

Although some pastors had a personal perception about the validity of the field, a few of them mentioned that their opinions were not necessarily shared by the pastoral staff alongside whom they worked.

*Pastor D: It's a hugely, at times not confusing, but polarised feel in the church, and I think also the sense of medication now....*

Pastor D mentioned that the leaders within his church are “split in opinion” about the value of the field, their perception of it as a science, and their readiness to refer congregants for this type of “treatment”. In this statement, it is clear that the fields of Psychology and Psychiatry are merged in his perception, and therefore his opinion of the two disciplines is intertwined. This pastor was able to recognise that he was ignorant about what the disciplines entail, but that his perceptions were formed by the influencing factors mentioned before.

Pastor D further expanded on his view of Psychology in saying:

*Pastor D: Psychologists, some of them are brilliant fathers and mothers and counsellors that are just saying “your context is not so bad” ...*

Although the tone of Pastor D’s comment was an affable one, the latent meaning implies that the primary role of a psychologist is to contextualise their clients suffering or pain by placating them, or comparing their pain to more extreme circumstances. Although there may be some validity to the psychologist contextualising pain, the use of the word “just” implies an undermining of the professional training and scope of practice that Psychology entails.

The lack of unity and agreement in leadership about the usefulness and validity of the field was phrased by Pastor F in this way:

*Interviewer: Do you find some of that in your work that you.. that there are differing views when it comes to this topic or do you think people are very united in their opinion?*

*Pastor F: No I would, definitely not..... we're... I will almost say we're fighting one another so I agree there are spaces where if you have not studied at a seminary doing biblical psychology then it's almost like we shouldn't be sending our people there...*

Pastor F is referring to the fact that there is disunity in opinion about the authority/validity of Psychology. It has been his personal experience that some colleagues do

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not recognise Psychology as a valid science if it is not based within infallible biblical truth, which is what biblical psychology is perceived to be.

Pastor G reflected on this perception by saying:

*Pastor G: On the more conservative, Baptist side, it's just disapproval, the Lord is sufficient, the Word is sufficient, you know those sort of words, and where we don't need these other things, and I think from the more Baptist side, the history was almost it's getting.....secularising....we are secularising the gospel, Christ is enough for all and almost liberal, so, those kind of taints...*

Pastor G says that a perception exists among some that the concept of biblical sufficiency is irreconcilable with the field of Psychology. Psychology is seen as an attempt to usurp the authority of the Word of God by providing alternative options for dealing with life's challenges and distresses. In this excerpt "Secularising the Gospel" is described as Psychology's desire to replace biblical knowledge with secular theory.

The fact that Psychology is a multi-faceted field, comprised by a plethora of theories, further undermines its perceived validity:

*Pastor H: I think Psychology, you know there are so many different schools of thought. It's not like a... so, I think it's very difficult to generalise and I don't want to generalise, but I think it's, as a whole it's a fair minefield. It depends like, like what you subscribe to or not. What will you follow and so, it all depends on like where you're coming from, you know. What you hold to, what your world view is as a psychologist*

Pastor H equates the number of different schools of thought in Psychology with a minefield. This association is due to the perception that the field seems to lack a unifying and coherent theory to depart from, and in which it is anchored. On this basis, Pastor H said that he has pastoral colleagues who will not make use of psychologists or psychiatrists.

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It is not only the lack of a unifying theory that contributed to questionable science, but the interpretation of what constitutes a disease and how that can be scientifically verified:

*Pastor I: So when we are talking about depression as a disease, that's my question is, what disease is that? You know, what as a clinical psychologist, will you want to know what is actually causing it and is it a brain issue you know, I don't know if you go into the chemical imbalance world and even that, I mean how do you diagnose that?- How do you diagnose a clinical imbalance? and what is the test?*

*So the issue then is, the issue of having information you know data actual physical data on a situation and then finding out how that data should be interpreted. You know interpretation is the key issue.*

*So for example if we can say all right, this person is depressed, because on this scan this is a normal person's scan and this is a depressed person's scan and you can see different brain imagery. We want to know what does that mean? You know what is... what story are they telling?*

*You've got a scan, so, what is, what is the final authority. You know how do you ever validate what that means in a person's situation?*

*Now isn't it possible that the result of scan is you know, is the... what you are seeing on the scan – is it the cause or is it a result of a person's depression?*

Although Pastor I acknowledged that the presence of physiological malformation, deformity, or certain illnesses is verifiable and undeniable, he did not include psychiatric diagnoses in that category. Conditions such as cerebral palsy and cancer were seen as examples of “real” illness, whereas depression and anxiety were not interpreted as illness. Pastor I gave an example of people who suffered from Post-Traumatic Stress Disorder as most definitely requiring medical treatment, and he was also in favour of medication for depression or anxiety if absolutely necessary. This did not imply agreement that these conditions marked a verifiable illness or disease, however, as noted in his query as to how, for example, a MRI scan result is

interpreted. This discussion carried over into an extrapolation on how the two disciplines (Psychology versus Theology) classify “truth” and by what authority this truth is verified.

Some of the pastors believed and clearly stated their perception that Psychology is a legitimate science:

*Pastor A: I feel that as much as God works through pastors in helping people get to health, physically, emotionally and mentally God has also given the medical field, the area of science. I can see that they are people who have studied, they have gone through the science, they have experiences, they have seen different kinds of cases.*

*Pastor C: I had many research (projects) and I draw a lot on statistics as well and that comes from research you know, and I think, I think you know that's exactly uh the same really in the psychological field and I know a lot of your conclusions is drawn from that - that kind of research you know.*

*Pastor E: Science - ja. I think that there's there's a lot, there's a lot of um research that's gone into it.*

*Pastor F: God gives to the body all sorts of professionals. Not to depend on them as we need to depend on Him but He does give them to us and so it would be foolish for me to lean to the “name it and claim” it.*

Pastor F was referring in this comment to the fact that both psychologists and psychiatrists are valuable resources to the church, and that God gives the church these professionals so that treatment can be sought when necessary. Therefore, he would not lean on the assumption that faith, prayer, or the proclamation of healing in and of itself would necessarily be sufficient in resolving mental health diagnoses. His endorsement of the field in the above comment was made in reference to his agreement that the fields hold scientific validity.

**Subcategory 1.1.1: Factors influencing the perception of Psychology as a science: training and professional development:**

The perceptions of the pastors about the scientific validity of the field were influenced, not only by personal experience, but also by the training that they had received in seminary institutions.

Pastor B started the interview by asking if he could read me a quote from a book that has formed part of his professional development over the last few years. Pastor B agreed with this quote and added that his own fears and concerns about the field are similar to those mentioned by the author in the insert below:

*Pastor B: When people don't feel good, they believe something is wrong in their lives. Cultural commentators had note that therapy and counselling had become a kind of soul religion in the Western world. One of the key components of therapy is that it removes any objective moral claims and instead focus and subject the feelings of the client.*

Other pastors similarly reflected on how their perceptions were influenced by their training:

*Pastor C: I had the privilege of you know being lectured by psychologists at the seminary where I was at and so I would reckon that that probably broke the whole thing of being nervous when you have a psychologist speaking to you or or whatever..*

*Pastor D: And we want to take a troubled soul, connect them to God. You know? And so, again, that's why it's a great discussion. If you get under the bonnet of the pastors, they've been told in a seminar or seminary, you know, they've been drilled, that's been drilled into them. And so if you take that away from them.....?? And I've noticed at times, guys (congregants) say "should I go to a counsellor?", and I'm thinking hmmm, I think this one you should handle.....You know?*

*Pastor G: (from the) Baptist side, it's just disapproval, the Lord is sufficient, the Word is sufficient, you know those sort of words, and where we don't need these other things.....*

(Pastor G was trained at a Baptist seminary institution)

*Pastor H: Ja, so at seminary, we had a... I remember we had like, it was Jay Adams versus Larry Crabb in those days. So we had to... so I was more like Larry Crabb, because I thought Jay Adams was.... although I liked the Bible part I thought it was too simplistic, you just repent of everything, just repent, read the Bible and repent. It just doesn't seem right to me.*

*Pastor I: I think it's very likely that even the Baptist pastors that you have interviewed will be taking a biblical position different to what I hold and I say that because I am sure you have been exposed to this but, the position I come from is what they call "nouthetic counsel", nouthetic if you want to be technical.*

(The quote in its entirety cannot be included as it would endanger the confidentiality of this participant. However, he goes on to clarify that his training in nouthetic counselling has been the most formative in developing his perception of the field of mental health, because this form of counselling holds unwaveringly to the belief of biblical sufficiency, in that the Bible is the only source of wisdom that is required, in contrast to the wisdom of psychological science).

In each of these excerpts, it is clear that the pastors' perceptions were influenced by their formative training years. However, it was also implied by many of the pastors that their perceptions had changed over time in comparison to their early years in ministry through further professional training, and life experiences.

**Subcategory 1.1.2: Factors influencing the perception of Psychology as a science: the opinions and experiences of leaders in authority, the experiences of congregants, community members, or family members:**

In order to protect the anonymity of the pastors, a table has been created to reference the frequency of articulated perceptions that are evidently influenced by and linked to the opinion of leaders, or the experiences of relevant family and/or community members. This

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information will be included without reference to the specific pastor who made the particular statement mentioned:

*Table 8  
Perceptions Pertaining to the Influence of Leaders, Family, or Community Members*

<b>Quotes Pertaining to Influence of Leaders</b>	<b>Latent Meaning and Context of Quote</b>
<i>Our leaders....how our leaders feel about it.... I agree with (leader named), one of our pastors, and one of our senior pastors.</i>	His perception is influenced by the opinions of his direct senior leaders
<i>Subsequently (leader named) has done Christian psychology and then our (leader named) has looked into the field of Christian psychology too</i>	This pastor's leaders accept the field of Psychology, primarily if it is Christian psychology versus secular psychology
<b>Quotes Pertaining to Influence of Community or Family Members</b>	<b>Latent Meaning and Context of Quote</b>
<i>Because I was brought up I suppose with the same perceptions sort of as everybody else about psychologists. I in my bringing up, my culture if I should use that word, psychologists were and I'm thinking about the certain phrasing that was used.... for psychologists... Uh a "mal dokter" (doctor for crazy people) , 'mal dokter gaan sien' (to go and consult with a doctor for crazy people) and you know 'cause it immediately puts you in a place where you are mad you know. That word was thrown about quite a bit. And so the moment you are referred to something like that then someone whoever refers you would say "jy's mal!" (you are crazy). You know that has always been the thing and I suppose, because I come from there my perception was like that, you know ooh to see a psychologist uh</i>	This refers to the way that the community in which he was raised would perceive the field of mental health, which impacted on his own perceptions. This pastor clarified, however, that although this jargon and this stereotype still exists within his community, he has seen a decrease of this perception over the last few years.

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<p><i>psychologist is actually a nice word still - nice term but those were the kind of terms that we, that was used</i></p>	
<p><i>I don't see my family member out of Psychology, either twice weekly appointment, it costs her a flipping fortune and I don't see her getting out of it. It is like she's locked in there.</i></p>	<p>The pastor has a family member receiving treatment and he is concerned that a dependency is being created between his family member and the professional. The latent meaning and implication here is that the main benefit is a financial one, on the side of the professional. This has undermined his perception of the validity of Psychology.</p>
<p><i>In terrible cases like rape and that sort of thing, you really, you need, when people are neurotic and they can't sleep at night, you know. It happened to my family member (identifying details of being victim of violent crime) and she just for months she was absolutely terrified. Shaking all the time and so we saw that terror and we understood how real that was and how necessary it is sometimes to have something to just calm the physical body down while you trying to get your head together</i></p>	<p>The pastor made this comment in the context of the usefulness of medication for certain psychological or psychiatric symptoms. His perceptions were altered by his family member's trauma and he recognised that medication made a difference in her situation, therefore it might make a valuable difference to others.</p>
<p><i>So, (name of wife) was like can I go? Can I go? Can I go? I said, is was kind of saying kind of, yes, if you need to.. but – and then she went and it was like, okay, well, not that she was disappointed, but it wasn't as if, you know, what they were giving her got her over the mountain she was facing...</i></p>	<p>The pastor's wife was battling with despondency and asked if she could see a psychologist. There is a latent meaning here in the fact that the wife felt she needed to ask the husband if it was permissible for her to see a psychologist. The nature of her request was not a financial one, this pastor implied that the wife's concern was whether or not he would approve of her seeing a psychologist, which implies the wife's knowledge that her</p>

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	<p>husband has an apprehension and nervousness towards the field.</p> <p>Secondly, the wife's experience with the psychologist is described in a way that indicates that she had been underwhelmed, and that it had not assisted her in overcoming what she was facing. This example was used by the pastor later in the interview to refer to the fact that it substantiates his perception that only God can truly bring full healing, and that the role of Psychology is a decidedly subsidiary one.</p>
<p><i>...going back onto the medication and following the procedure yes there has been a great improvement....</i></p>	<p>This pastor witnessed the deterioration of functioning in a community member who had been non-compliant with his psychotropic medication. Once the person went back onto the medication, there was an improvement in his functioning. The pastor linked this story to the fact that in certain cases he now does see the necessity for and value of psychotropic medication even more so than before he witnessed this unfold in the community member.</p>
<p><i>There been occasions where they've been told to do things that I've been very sceptical about and so it might be something some are of their sexuality, divorce, or it might be some therapy that they've got to go to and go through or whatever the case is that I've been very sceptical in terms of what kind of advice had been given in that and so those things have definitely happened.</i></p>	<p>This pastor has had congregants who have gone to therapy and the counsel received, specifically in reference to sexuality and divorce, has been of a nature that the pastor strongly disagrees with. This has made him sceptical of the validity of what the professional in the field of mental health has suggested. This has, at times, undermined his perception of the field.</p>

<p><i>We all know there are those who seem to have come out of a situation where it turned to the more selfish, I think it happened with my own family member, so I feel a bit strongly about it.</i></p> <p><i>...but you can never judge the counsellor by the counselees</i></p>	<p>The pastor's family member had received advice from a psychologist for his marriage that the pastor felt to be egocentric, and therefore, caused him to behave in a selfish manner, according to the pastor. This was linked to the perception that the field of mental health can be overly focused on an individual's need to "self-actualise" at the expense of others.</p> <p>However, this pastor was the only one who overtly acknowledged that counsellors (in whichever field of mental health) can be misquoted and misunderstood, or even used as the scapegoat to justify a person's decisions. He felt this to be unfair on counsellors, and a disservice to them.</p>
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As can be seen from the above tabulation, the perceptions of the validity of Psychology and the field of mental health at large are often influenced by people in the pastor's immediate environment. This leads to the formation of perceptions based on, quite often, the vicarious experiences of others, which nonetheless form a powerful and lasting impact.

**Subcategory 1.1.3: Factors influencing the perception of Psychology as a science: first-hand experience with the field:**

It was noteworthy to see that a number of the pastors had themselves been diagnosed with or treated for psychiatric conditions. Each one of the pastors explained that their first-hand experiences with for example, depression or anxiety, and the manner in which it had been treated, had a monumental influence on the formation of their perceptions about the validity of the field of mental health.

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Pastor G mentioned that his perceptions of the field had initially been formed by the tension he experienced within the church setting between the field of mental health, and the role of the church. It was only when he developed depression and was desperate for the treatment thereof that his perceptions began to shift:

*I hit a major depression in my forties and I got to the point where I was not coping. While I was in the ministry preaching every Sunday and I went for psychological help and medication. So, in that I carry a deep knowledge that it can really help, because I'm not depressed now, and I've coped for years and years.*

*.....That really help me and even saved me through a very difficult time.*

It was through this personal process that Pastor G's approach to dealing with the psychological distress or psychiatric diagnoses of his congregants, and with people close to him, began to change. What he faced through this change, however, was some disapproval from colleagues:

*At one point I was criticised for being too psychological.*

This did not deter Pastor G though, and he continued to advocate for an openness to the field of mental health, and the treatment that could be provided:

*And I've been able to say from the pulpit things like you may well need medication for your depression and not had very much kick-back from saying that. So, I think in my church it's safe to say it's been ... my approach has been happily looked on by most people.*

*.....it became more accepted that people went for therapy or something, or medication.*

Through the way that he has communicated about mental health to his congregation, they have begun to demonstrate greater openness and understanding of its potential to be a resource to them. The content of the above quote was one where thematic analysis showed its relevance over two themes, the second being the Personhood and Role of the Professional, which will be discussed further on in this chapter.

Three other pastors had personally received psychiatric or psychological treatment, but the nature of their experiences, and the trajectory that this had on their perceptions differed to that shown above.

Pastor B had the personal experience of depression, and it resulted in two varying processes. The first outcome was an increased understanding of depression, and a compassion for those suffering from depression. However, Pastor B also had an encounter with a psychiatrist during this time that left him with unanswered concerns about depression, medication, and the professional credibility of some individuals within the field:

*I think people do not really understand depression, I never did, till I got depressed, I always thought it was a weakness ... a human weakness, till one day it hit me, then I realised this is real and I think it is very hard to climb out of that, out of a dark hole. I actually ... I carry deep sympathy for people with depression. I know it is a deep ... (sentence left incomplete)*

The tone in which Pastor B left this sentence incomplete was a poignant one. It was permeated with a sense of sadness and an inability to articulate the depth of impact that depression left upon him personally. His personal experience, along with the experiences of people in his congregation, seem to have left him with piteous memories, hence his empathic attitude towards it.

His encounter with the psychiatrist, however, evoked a dissimilar response:

*I was at a function with a psychiatrist and I just tell him I was battling to sleep, and he gave me a script, wrote a script at this function, and I went to a doctor and it was a massive doses of anti-depressants, massive, I'm talking about highly powerful drugs, which I didn't take, it was just incredible that he could literally be sitting opposite me at a function, writing a script for me to sleep better.....?? I think, my dealing with Psychiatry is, I don't think it is as much science as people make it out to be. My perception, so I'm not saying I'm right, I just saying my perception is I don't think it is a science, because I see it play havoc with people, especially those bi-optridrugs and emotion optridrugs,*

*I think there is a suicidal tendency in some of those anti-depressants. That is my perception.*

*(Details of where this encounter took place have been altered to preserve anonymity)*

This encounter made Pastor B far more apprehensive about the use or prescription of psychotropic medication, and it raised questions about the validity of the science of Psychiatry. Pastor B clarified at a later stage in his interview that he acknowledges that there are some people who do require medication, but he has concerns about who prescribes it and how much is prescribed, factors that will be discussed later in this chapter.

Pastor H's following experience took place when he was in his twenties. As such, the treatment protocols of the day differ greatly from several of today's accepted protocols. That being said, the traumatic nature of that experience has had a lasting effect on the formation of his perceptions:

*... I've had quite a lot of experience, not lately, but when I was about twentyish I had major episodes. So, what... and what struck me then is that....like the psychologist I had was... some of them were like the most unhinged people I've met. Like colourful marmots. Those guys were like... those guys were like... I know for a fact they were like self-medicating, overindulging in stuff like they would kind of give you...*

*I spent time in two different major sort of... I call them "loony bins". It was rough..... It was like "One flew over the Cuckoo's Nest" in the eighties it was rough then. It was like rock up, put straight into the straitjacket. Shock therapy, forensics stuff.....*

*So ja, look well I can't really say what made me better apart from what the grace of God did, but I can't say what human instrument or what human program or what human... but I was very... I just don't think that those guys really knew what was going on. That's the bottom line.*

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When recalling these memories, Pastor H displayed emotional anguish in the tone of his voice; his recollection of these memories was communicated in a more disjointed manner than the other parts of his interview. This is indicative of the lasting trauma that Pastor H carries in relation to his personal experience. He also attributes his ultimate healing to the realm of the supernatural; a topic which will be explored in Theme Two: Point of Departure of Pastors. It must be mentioned, however, that when reviewing the narrative of his interview, it is clear that although his traumatic personal experience had impacted on his perceptions of the field of mental health, it had not completely dissuaded him from seeing the benefit thereof:

*I would not throw the baby out with the bathwater, I am just cautious. And there are a lot of cases like that where guys are like severely depressed, I mean I think..... I think there is a place for medication, despite the fact that I think people are over medicating that doesn't mean that there isn't a place for medication. So I think there is a place for medication and we have referred people to a medical fraternity or psychiatric or psychological fraternities, because of that.*

Pastor I had also been referred to a psychiatrist and a psychologist for treatment, which impacted his perceptions:

*When I went to the psychiatrist he started asking me about what was going on and I was explaining to him, because he was a Christian psychiatrist, I don't know what you call a Christian psychiatrist but um... so he... I explained to him what was going on and all the conditions that I was facing and things that were exhausting me. So when he, when it came time for me... for him to begin to advise me on what I should do, he started, he opened a text you know from the Bible.....The prescription was numerous times every day I must say a certain phrase like 5 times a day (details thereof omitted to protect anonymity) and it was like..... that was it..... That was my therapy from a psychiatrist. That was my sole personal experience you know, I was burnt out, and it was pretty laughable, I can assure you.*

In reference to a psychologist he knows personally:

*She has people come to her practice, she tries to help them with her “Psychology technique” and then in her private capacity she tries to bring the Bible in and I don’t know.....I personally feel very suspicious about that ..... I have realised that if God doesn’t change somebody...technique is useless*

Pastor I used the words “pretty laughable” to describe his experience with the psychiatrist he saw, and mentions that this was his “sole experience”. This was punctuated in the interview to communicate that his first experience was his “sole experience”, given that it was such a negative one. It is noteworthy that Pastor I commented that this was a “Christian” psychiatrist, and that he isn’t sure if that’s what you are actually allowed to self-label as a psychiatrist, within the regulations of the discipline. His disdain for this encounter was tangible and had caused him to be dubious in his opinion of their competency. His opinions of the field of Psychology have been influenced by his interactions with a psychologist that he knows personally, and with whom he has had discussions about the validity of how she approaches the treatment of clients. He used the words “psychological techniques” to communicate his doubt as to the efficacy of these techniques. He also expressed disapproval for what he perceives as a superficial use of the Bible, which he was very suspicious of. By stating “*I have realised that if God doesn’t change somebody..... technique is useless*”, Pastor I implies that a psychologist’s techniques are redundant unless they use God as the main source and focus of their treatment. This was confirmed in the following exchange that took place when Pastor I was asked if he believes that psychologists can still be used by God in their profession, even if they do not directly and overtly bring the discussion of God into the session:

*Say, um, if... if you can do it in such a way that you bring a person face to face with his Maker, if you can do that in a psychological setting, I believe you’ve met God’s mandate. But if you have to help somebody to heal, or whatever other word, you know, progress outside of that, if you can’t... if you can’t... if that’s not the main point in what you’re doing, I don’t believe that that meets God’s mandate. That’s the way I would understand it.*

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Pastor I is of the opinion that if psychological treatment is not directly bringing a client to a place of encountering God first-hand, then the psychologist is not meeting God's mandate for true healing. This is Pastor I's perception, but he acknowledged that this perception is shared by many of his colleagues who have similar training in pastoral counselling.

This section has considered the factors that influence pastors' perceptions about the scientific validity of mental health professions. Their perceptions seem to be impacted mostly by their own personal experiences, as well as the experiences with mental health field of their congregants, community, and family members. The pastors' general perceptions about the field of mental health were thus influenced by the following factors, listed in order of frequency throughout the transcripts:

*Table 9*  
*Factors Influencing the Formation of Perceptions in Pastor Sample*

<b>Factors Influencing the Formation of Perceptions in Pastor Sample</b>
1. Personal experience
2. Family of origin (how their own families dealt with and communicated about mental health difficulties)
3. Community members (how community members dealt with and communicated about mental health difficulties)
4. Vicarious experience of congregants and family members
5. Experiences and opinions of their superiors (church leaders to whom they report)
6. Experiences of pastoral colleagues
7. Early training in seminary or Bible colleges

**Category 1. 2: The Fears and Concerns about the Field of Mental Health that Impact on Perceptions:**

The second category that influenced the pastors’ general perception of the field of mental health was the fears and concerns that they have about this field, and of the professionals that practice within the field. Some of these fears and concerns were born out of the experiences that were mentioned in the section above, experiences that the pastors had lived through, or experiences that congregants and family members had reported. Most predominantly the pastors’ fears were rooted in the following categories of concern: glorification of the individual; dependency; labels, lived identity and abdication of responsibility; the mental health practitioner’s purpose in relieving psychological distress, and the personhood of the professional.

**Subcategory 1.2.1. Glorification of the individual**

Eight of the pastors were unified in their perceptions that the field of mental health treats clients on an individualistic level without due consideration for and involvement of the communities in which they are embedded. A summary of the statements made by the pastors in this regard and the context thereof follows:

*Table 10  
Pastors’ Quotes Pertaining to Glorification of the Individual*

<b>Quote Number</b>	<b>Quote</b>	<b>Latent Meaning and Context of the Quote</b>
1	<i>I say it has a process that doesn't really take into consideration those kind of dynamics from parents and brothers and sisters and so on. I don't know that's just my opinion.</i>	The pastor is referring to the process of therapy that seems to focus on treating the client but does not take family dynamics into consideration. This contrasts his opinion on how situations should be handled systemically.
2	<i>I think community is so important, because you need people around you to be able to kind of see the blind spots in your life and go you know there's,</i>	The importance of being embedded within a community of people was emphasised by this pastor as one of his fundamental beliefs. Although he did

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	<p><i>actually there is no sin in your life it's just the brokenness in this world, so we need to do community better. We're really bad at it, we believe the lie that we're created for isolation, so we need to do community better. We need to be honest and vulnerable, push beyond transparency, and I think we settle for transparency so we need to push beyond that - be vulnerable with each other.</i></p>	<p>not overtly state that the field of mental health elevates the role of the individual, he makes it clear that people ought to find community so that vulnerability can be fostered. Through this vulnerability, the pastor implies that a form of spiritual accountability and healing can be created. He refutes individualism by saying that the belief that a person is created for isolation is a lie; it is refuted by a need to place oneself within community. Therefore, this community must be considered when assessing the context of an individual.</p>
<p>3</p>	<p><i>Sometimes they see the client as isolated from the bigger picture so they don't see the children and they don't see the husband and they don't see the greater family, and how it all fits together and works together and they deal with the ind... which is important, you have to deal with the individual so in some ways it's not criticism in other ways it is a criticism, because it's a very self-centred, selfish kind of approach. They tell the client that they're the most important person, they must take care of them, take charge of their life and they must resolve this issue for themselves and they must discover, but there all these other people</i></p>	<p>Psychologists are seen by this pastor as treating individuals in a way that causes them to disregard the impact of their decisions on those around them. This is seen by the pastor as being selfish, and as resolving issues purely for the individual's benefit, without balancing or practising the importance of self-sacrifice in the context of relationships.</p>

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	<p><i>involved. It becomes become very exclusive in terms of its approach that it's just about me. So it's about me and my happiness only, what's right for me and, and telling all the people around me whose happiness this will affect and so that, that self um sacrificing, self-giving aspect of relationship often is the thing that is ignored</i></p>	
4	<p><i>There is some sort of directive given in some way, there is a way put forward, so now what is that way.. is it... is it like a holistic thing? Does it involve the church, the community? Does it involve medication?</i></p>	<p>The pastor was expressing his concern about the treatment plans that psychologists or psychiatrists give their clients. Before he could endorse the treatment plan given to one of his congregants, he would first want to know if the plan includes the church and the community. His desire is to have a congregant treated holistically, and for the church to be integrated into this treatment as part of the client's community.</p>
5	<p><i>...He would have been counselled in the area of self-actualisation, which he turns to selfishness.....</i></p>	<p>This statement was made within the context of a family member of the pastor who had been told to focus on self-actualisation, which was translated by that client into selfishness. This pastor took a dim view of the way in which Psychology may have enabled selfishness, but he also acknowledged that it was not possible to know with certainty if it had been the client's interpretation of the psychologist's</p>

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		instruction that had led to this selfishness. Nonetheless, the pastor was left with a concern that clients may become more self-focused when treated by some psychologists.
6	<i>I suppose the world we're moving into is a "me world" and a "my world". And I suppose your profession is hugely around ... Individualism.</i>	The pastor was describing society as progressing towards being self-focused, and selfish in that focus. His perception is that the professions in mental health both perpetuate and encourage a focus on self by heralding individualism.
7	<i>It was in a case of severe depression that I saw a change, through becoming the guy's friend, through seeing how he had sinned against God through bringing reconciliation between him and God, and reconciliation between him and the people that he had sinned against. And strangely God brings, through that reconciliation, God brings subjective peace to the individual and transforms him.</i>	The pastor used this example to illustrate his approach to counselling people. He forms a relationship with the counselee and brings them to a place of reconciliation with God as the highest priority. Once that reconciliation has been facilitated, the counselee is required to reconcile with people in their community and their lives to whom they may have caused pain. The latent meaning in this example is the fact that reconciliation with community is second in importance only to reconciliation with God. Therefore, the role of reconciling relationships with others is seen as a critical component of healing. The pastor does not think that Psychology emphasises reconciliation with people, which he takes exception to.
8	<i>I think Psychology has affected pastoral and ministry in an incredible</i>	When the pastor described the effect that Psychology has had on pastoral

<p><i>way. So I think it has highlighted the individual to a role that I don't necessarily believe is Scriptural. So I think the healing of an individual is always community based. There is an elevation of the individual in Western society.</i></p> <p><i>The Hebrew and the Greek culture was more communal based, so their life was communal, the healing was communal, the responsibility was communal. I think the individual has taken precedence over that.</i></p>	<p>ministry with the word “incredible”, his connotation was not a positive one. Perhaps another suitable description would have been “in a substantial way”. The emphasis that Psychology places on the individual is seen by this pastor as being one that negates the necessity of involvement in community, and consideration of community when assessing clients.</p>
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The pastors demonstrated concern that the field of mental health places emphasis on an individual at the expense of the wider community that they function in. The pastors have a preference for an approach to assessment and treatment that recognises that the client is embedded within a system, and that this system must be given due consideration.

***1.2.1.1: Glorification of the individual through self-image:***

Linked to the pastors’ concern about individualism was their fear that the concept of self-image in psychology, specifically, is a construct that causes clients to focus on the individual and their own need fulfilment. The above quotes 3 and 5 mention “self-actualisation” as being linked to selfishness, implying that there is an inherent fear that Psychology may encourage people towards self-importance. To this point, Pastor E says the following:

*A simple thing like um self-esteem and knowing that my, my self-esteem is about who I am in Christ and how that relates to who I am as a person and how I must view myself now that I'm a believer you know it helps me to understand, and then self-esteem can be taken from two very different perspectives, the one can be from 'I'm a Christian, I'm a follower of Christ, I'm a child of God' and so I live in that reality. Whereas in, in some Psychology there's just like you, you're all good, this is all good, everything is good about you and then you're not recognizing that that's what that that tension of sin in our lives is, and so even*

*just in a thing like self-esteem, where people can understand that yes we want to encourage people to a healthy good self-esteem but based on what they believe in terms of their faith in Christ rather than on what, who they are intrinsically. I don't know if that makes sense?*

Pastor E is also highlighting part of his theoretical point of departure, which will be discussed in Theme Two. The pastor is stating that he believes there is an element of sin present in people's lives and that Psychology's assumption that a person is "all good, everything is all good about you", is contrary to his belief. He indicates his perspective that the disciplines differ on this fundamental point when he questions whether the interviewer thinks he is making sense.

Pastor I was manifest in his biblical perspective on self-esteem and how it differs from Psychology:

*We take a very strong stand on self-esteem.....  
And you know self-denial is the biblical picture, not...(self-esteem)  
Scripture shows that we love each other, ourselves too much and that's why we doing the things we are doing. We want more for ourselves. So...*

Based on the pastors responses about Psychology's focus on the individual versus the community, and their comments about self-esteem, there is a perception that the field of mental health creates an egocentricity in individuals that pastors are nervous about.

### **Subcategory 1.2.2: Dependency and a "functional saviour":**

A dominant theme, both in manifest and latent analysis, was the pastors' perception that the field of health often creates a dependency of clients on professionals. This was described in a myriad of ways by the pastors, but the quote that encapsulates the manifest and latent meanings across all the interviews was made by Pastor F:

*This tension is so uncomfortable when we try to remove God from the equation and in a sense try to make ourselves god so we are the ones that are in part responsible, we become the saviours, their functional saviour  
....let's just then remove God from the equation like maybe feeling like if He can't really help me then maybe Dr so and so can or Mr or Mrs whoever....*

This pastor clearly articulated that there is a danger in pastors becoming someone's functional saviour too, because whenever a person turns to another for their healing instead of turning to God, there is a danger that we turn one another into "functional saviours". Pastor F made this comment in reference to his fear that psychologists and psychiatrists become clients' saviours, and create a dependency on them that is misplaced.

The idea of a "functional saviour" can be identified within other pastors' perceptions too:

*Pastor B: It's like a coping mechanism, so he (psychologist) becomes the crutch and so you can't wait to see your therapist or psychologist, so they become a crutch to the emotion, so it's like a cripple walking around with crutches. I think your psychologist becomes a crutch, where I think we should rather get him healed so that people can walk without the psychologist, without the pastor, you know....*

Pastor B echoes similar perceptions to Pastor F in recognising that both a psychologist and a pastor can become a person's "crutch", which prevents them from being fully healed by God. There is a dependence on this "crutch" rather than a dependence on God.

Pastor D agreed that there is a common perception amongst pastors that professionals in the field of mental health create a dependency. However, he added the following:

*But I think it's (the perception of created dependence) is unfair, because I think there needs to be a greater education as to what....you know....we've never heard from the pulpit or anywhere, this is what a psychiatrist, this is psychiatrist or psychologist can do.*

*And so have a lot of negative, in fact, many testimonies are negative.*

Pastor D picks up on an important point in this comment, although he knows that the perception exists, he attributes misperceptions to the fact that there is a lack of information and education available about the field of mental health. He goes on to say that the majority of testimonies he has heard within his church context have been negative ones in relation to the field. The latent meaning in this last sentence can be related to subcategory 1.1.2 which shows how easily perceptions can be formed by the experiences of congregants or family members.

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Perceptions get shared between people and therefore have the potential to contribute to misperceptions.

Pastor H reflected that one of these misperceptions that he notices in his church is that congregants sometimes feel as if they have not been effectively assisted unless they have seen a professional. He felt that this undermined the validity of the church as a resource when people are in distress, and that it contributed to a dependence on professionals as having the ultimate answers.

Pastor I's articulated his concern that psychological treatment produces dependence by questioning the source of the psychologist's own dependence when treating people:

*We don't depend on the technique; we know that without the Holy Spirit, we give up.*

With a psychologist's perceived dependence being on that of technique versus the Holy Spirit, the pastor went on to explain the damage that can be caused when a client then becomes dependent on the psychologist and their technique:

*You know, and that's the thing where I fear that applying psychological therapy to make people "happy" is making a person who is spiritually dead go to hell "happily". I will say that frankly it's blind leading the blind. You know a person who has got techniques to make... I will use my impression.... to make people "happy" so they can dance to their grave and face the wrath of God.... that's so pointless.....*

The latent meaning to the above quote can be interpreted as the pastor's fear that a dependence on psychologists and their techniques may lead to temporary happiness, but if the person does not get healed by the Holy Spirit, and does not come to salvation in these techniques, then that person will inevitably still face God's judgement.

The above perceptions of the pastors demonstrate the ways that their perceptions are informed by the fear that a dependency is unduly created by mental health professionals. This

dependency usurps the role of God as the primary source of healing and as the only area in which adaptive dependence should be formed.

**Subcategory: 1.2.3: Labels, lived identity and the abdication of responsibility:**

These subcategories were clustered together, because they relate to one another strongly in how the pastors explain their perceptions. In general, many of the pastors were concerned about the use of diagnoses which leads to people personifying their diagnoses and thereby abdicating responsibility for their behaviour.

The relevant quotes for this subcategory will be presented in a table with the context and latent meanings included. There are 9 quotes expressed by 6 pastors below:

*Table 11  
Pastors' Quotes Pertaining to Labels, Lived Identity and the Abdication of Responsibility*

Quote Number	Quote	Context and Latent Meaning
1	<i>It seems to me that some conditions - people just default there too quickly, like... like... it just seems like just about everyone who's got issues is bipolar or manic. Which... I'm sure people are bipolar and manic, but it just seems to be all over the place.</i>	The meaning here is a manifest one, the pastor is obviously concerned about the prevalence of diagnoses, which undermines his confidence in the use of diagnoses.
2	<i>You know if it happens that somebody has a disease of depression and, because he has this disease he can't speak to his wife in a kind way, you know he is going to sin against her by being rude with her, angry, you know, and this is identifiable sin. Then you're going to say you know, this is... this is not meshing with what theology teaches us.</i>	This example was used by the pastor to indicate that a diagnosed "disease" should not justify engagement in sinful behaviour. This is something that the pastor would point out to the person as being incongruent with biblical teachings.

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<p>3</p>	<p><i>For me, it's about helping this little person recognize their identity in something other than that (diagnosis), because if they're going find his/her identity in being transgender the rest of his/her life, he's going have struggle in that for the rest of his/her life</i></p>	<p>The example of transgenderism was provided by this pastor to illustrate his concern about a young child's diagnosis becoming the foundation on which the child's identity is formed. The pastor's preference would be to have the child's identity formed in his/her identity in Christ and not in his/her diagnostic identity.</p>
<p>4</p>	<p><i>Interviewer: So are you saying that there's a danger in Christians making mental health professionals or pastors the functional saviours and abdicating responsibility for their own recovery? Pastor: Ya, ya and that's a real issue I think</i></p>	<p>The interviewer's question has been provided so that the pastor's answer can be seen in context. The interviewer was summarising a previous point that the pastor had made by ensuring that she understood him correctly. The pastor's answer reflects that he thinks the abdication of responsibility for an individual's healing becomes a danger when that individual sees the professional as their functional saviour.</p>
<p>5</p>	<p><i>My perception sometimes of Psychology is it creates a babyhood as supposed to releasing people into adulthood, it's just a perception. But I think it is a real perception.</i></p>	<p>When reviewing the latent meaning of this quote, the use of the word "babyhood" would imply a state of immaturity, dependence, and helplessness. This is contrasted to "adulthood" which would be paralleled to greater levels of maturity, self-control, and forward movement.</p>

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		The pastor fears that Psychology creates a babyhood where people can abdicate responsibility by staying in a helpless and dependent state.
6	<i>Even under difficult conditions people have the choice on whether or not to do what's right and do what's wrong. So we want to be as careful as we can to distinguish between those things. So when we talk about depression as a disease, then I want to say what disease? I want to know how you diagnosed depression, what's actually happening in the body that you can have a label called disease, what virus is there, what malfunction is there in the body for you to come to that conclusion?</i>	Not only is this pastor referring to his perception that people are able to choose right versus wrong behaviour regardless of their circumstances, but he is also questioning the scientific validity of diagnoses, as shown similarly in Chapter One. He is referring to his perception that depression and other psychiatric diagnoses cannot be verified scientifically, and may, therefore, not be accurate descriptors.
7	<i>He's now being diagnosed as bipolar and he has been placed on medication for bi-polar. And I said, you know what....You don't have bipolar, you've got laziness and I dealt with hundreds of people, he has laziness, so I think it is an immaturity issue. So he (psychiatrist) puts this guy on medication and it worries me. I don't think he needs to go on medication.</i>	The pastor does not agree here with the diagnosis or the label of bipolar. The person used in this example is a person that the pastor knows well, and so he feels confident in his disagreement of the diagnosis. Rather, he sees the behaviour that is being classified as a diagnosis, to be more accurately described as laziness and immaturity. His perception of the nature of this person's symptoms is incongruent with that of the psychiatrist. This person is now living his diagnosis without

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		being held accountable for his behaviour.
8	<i>The sort of psychoba.. that... the constant blame shifting. It's never like me as opposed to.....there's always... there's always a reason why you like this and it's never you.</i>	The pastor did not complete the word “psychobabble”, most likely due to his hesitation to offend the interviewer. However, the latent meaning of his sentence can be understood within the context of the omission of the full word. He sees “psychobabble” as allowing people to shift responsibility by blaming other factors for their behaviour. Reasons are found to rationalise behaviour, but the person never takes personal responsibility. This is a troublesome dynamic in the pastor’s opinion.
9	<i>It makes people to embrace the disorder or to embrace whatever they are facing as a form of their identity</i>	The field of mental health is seen here to promote the embracing of a disorder so that it becomes integrated into their identity, which is a concern for this pastor.

From these responses, the pastors reveal fears regarding a general abdication of responsibility granted by mental health professionals. Sometimes this is done in the context of providing a diagnosis as a justification for behaviour, and at other times it is due to a person merging with their diagnosis and shifting blame to factors seen to be outside of their control. In contrast, the pastors advocate for personal responsibility and the formation of identity that is independent of a diagnosis.

**Subcategory 1.2.4: The personhood and role of the professional:**

As can be deduced from many of the responses provided in other sections, the pastors form general perceptions of the field of mental health and affiliated professionals based on their own experience, and the experiences of others. It has already been shown that some of the pastors are concerned about how professionals elevate individualism, form a dependency in people, and are complicit in people’s abdication of responsibility. These were categorised as fears or concerns that the pastors have about the field of mental health. Some of those fears and concerns were also indirect reflections of how they perceive the professionals themselves. In this subtheme, we will consider the more manifest perceptions that pastors had about the personhood of the professionals, and how they practice.

Many of the pastors shared the perception that psychologists, in general, are anti-spirituality and religion. The pastors were concerned that this resulted in psychologists removing God, or the mention of God, from their approach to treatment. This particular concern seemed to evoke passionate responses from the pastors, almost as the primary way in which psychologists and pastors are “worlds apart” – a term that will be elaborated on in Theme Three. The majority of pastors were unable to reconcile the concept of a person finding lasting and genuine healing in what was perceived as the anti-God world of Psychology/Psychiatry.

The perceptions of the psychologists and the role that they fill could be divided into a few subthemes. The subthemes, as well as the pastors who mentioned these subthemes, will be shown below; the subthemes below contain a summary of the quotes given by the pastors:

*Table 12  
Pastors’ Perceptions of Psychologists*

<b>Pastors’ Perception</b>	<b>Pastors Who Stated Perception</b>
Psychologists do not acknowledge the Power of Jesus to heal, or the sovereignty of the Word of God, they do not recognize the spiritual realm.	A, B, C, D, H, I
Psychologists do not acknowledge the role of sin in the manifestation of mental health problems.	A, B, C, D, E, G, H, I F (specified that it’s only some psychologists)

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Psychology does not always help the person in crisis	A, B, C, D, E, G, H, I
Psychologists lack a moral compass, because it does not point people north (to God)	B (included as a subtheme in order to show the type of analogies used)
Psychologists are often maladjusted themselves	B, C (psychologists are too clinical) D, H, I

There were some positive perceptions of psychologists and professionals in the field of mental health. Some of the pastors acknowledged that professionals can be effective and recognised the benefits of the field, as previously discussed.

*Table 13  
Pastors' Perceptions of Psychologists' Efficacy*

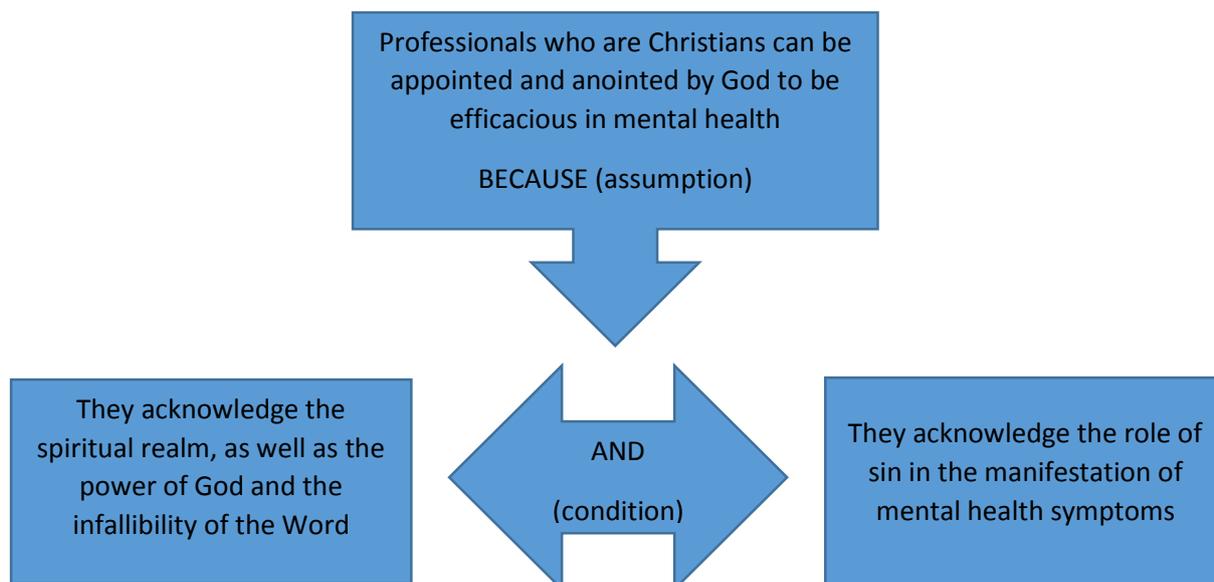
<b>Pastors' Perception</b>	<b>Pastors Who Stated Perception</b>
<p>God can use mental health professionals to bring healing –</p> <p>                    regardless of the professionals' personal faith positions;</p> <p>                    or, mostly only if the professionals are Christians themselves:</p>	<p>A, E, G</p> <p>B, C, D, F, H, I</p>
God appoints and anoints some Christians to be mental health professionals	A, B, C, D, E, F, G, H
<p>Pastors whose perceptions about the field of mental health were positively altered by personal interactions with:</p> <p>                    psychologists who were Christian;</p>	B, C, F, H

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or psychologists regardless of their personal faith beliefs.	A, G
Pastors who had positive interactions or experiences with psychologists where they themselves, their family members, or congregants were significantly benefitted by their treatment.	A, B, C, D, E, F, G, H

As seen in the above table, the perceptions of the pastors are mixed, although it can be determined that there are dominant trends. The perception that psychologists do not acknowledge the realm of the spiritual and the power of God to heal was linked to the perception that psychologists do not recognise the role of sin in the manifestation of mental health symptoms either. These two perceptions are related in the sense that a disbelief in the spiritual realm would carry over into the professional's recognition of the role played by sin. These were both given as reasons why the pastors think that Psychology is not always effective in dealing with a person's psychological distress oftentimes, because the origin of the distress may be spiritual in nature.

However, the pastors added to this opinion by differentiating between "secular" psychologists and "Christian" psychologists. The efficacy of the psychologist was linked to whether the psychologist was a Christian. The pastors felt that if the psychologist was a Christian, then that psychologist would approach the spiritual realm differently in his or her treatment of a client than how a "secular" psychologist would. 8 of the 9 pastors felt that God could appoint and anoint Christians in the field of mental health, and these Christian professionals could be efficacious. To some extent, these perceptions are fundamentally assumptive and conditional by nature, as shown in the diagram below:



*Figure 3: Pastors' Assumption about Christian Mental Health Professionals*

Figure 3 above would give rise to the essential question of whether it can be assumed that mental health professionals who are Christian subscribe to the two conditions that would endear a pastor's trust. The conditions whereby the pastors would feel confident to refer a congregant to a mental health professional will be elaborated on, along with the concept of trust, in Theme Three.

Many of the pastors specifically differentiated their perceptions of psychiatrists to their perceptions of psychologists. As was the case with the data pertaining to perceptions of psychologists, there was a mix of perceptions when it came to the psychiatrists' personhood and their role in mental health treatment. Every pastor noted that medication can, at times, be an essential and constructive component of a treatment plan. That being said, every pastor added a disclaimer to this perception by stating that they had personal experience of times when medication seemed to be flippantly prescribed, or prescribed in excessive dosages; that the medication had caused dependency; or that the side-effects of the medication had been intolerable for the person being treated. The pastors recognised that Christians are often apprehensive and fearful to use medication, because of the common belief that it creates dependency, or that it translates into a spiritual weakness to require psychotropic medication. Further concerns and fears that were dominant included that medication is used as a quick fix, but that it does not address the root of the psychological and/or spiritual distress. Relating to the personhood of the psychiatrist, the perceptions thereof were generally more cynical in

nature than the perceptions towards psychologists. Some of the pastors had been personally or vicariously affected by psychiatrists who seemed negligent, who were dismissive of their symptoms, who were overtly suspicious of their religious stance, or financially motivated above all. Pastors were also concerned that some psychiatrists and psychologists had misinterpreted spiritual tumult as being psychological or psychiatric symptomology, and had therefore applied the incorrect form of intervention to the spiritual one that was actually required.

**1.2.4.1: The pastors' rationale of healing:** Related to the subtheme of the role and personhood of the psychologist/psychiatrist is the subtheme of "the rationale of healing".

A few of the pastors expressed opinions around the rationale or reason for the relieving of distress by professionals. In essence, some of the pastors felt that psychological or spiritual pain is a natural and necessary part of life. The purpose of hardship is there to produce greater character, and a need for a person to shift from self-sufficiency towards dependence on God. The Scriptures that were used to substantiate this opinion were the Scriptures that Paul writes in his second letter to the Corinthians. For the purposes of contextualising and expanding on this theme, the passages of Scripture that were quoted by the pastors follow:

*2 Corinthians 12:6-11*

*New International Version (NIV)*

*<sup>6</sup> Even if I should choose to boast, I would not be a fool, because I would be speaking the truth. But I refrain, so no one will think more of me than is warranted by what I do or say, <sup>7</sup> or because of these surpassingly great revelations. Therefore, in order to keep me from becoming conceited, I was given a thorn in my flesh, a messenger of Satan, to torment me. <sup>8</sup> Three times I pleaded with the Lord to take it away from me. <sup>9</sup> But he said to me, "My grace is sufficient for you, for my power is made perfect in weakness." Therefore I will boast all the more gladly about my weaknesses, so that Christ's power may rest on me. <sup>10</sup> That is why, for Christ's sake, I delight in weaknesses, in insults, in hardship, in persecutions, in difficulties. For when I am weak, then I am strong.*

This passage of Scripture was quoted by the pastors to illustrate their belief that people may be given a "thorn in their flesh" in order to bring a realisation of their need for God's grace. The pastors mentioned that, similarly to Paul, sometimes a thorn is not removed, but

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God allows it to remain so that one can rely on God’s power when they are feeling weak. Verse 9 was also used to express the pastors’ opinion that Christians must embrace their weaknesses and tribulations in order to allow God to do a deeper spiritual work within them. Therefore, there are times at which the pastors do not think that professional help is warranted or required, but rather that a person relies on God’s grace and power as their source of strength. This is contrast to the idea of being “healed”, because the pastors believe that this “healing” would undermine a greater spiritual purpose to one’s distress. Some pastors mentioned that this verse is one where they have to show congregants that God heals in many ways, sometimes instantaneously and other times through a process. However, you can be supported through your hardship, and professional assistance may be one of those avenues. The opinions given by the pastors about this text can be best captured and summarised by including two of the pastors’ quotes:

*Table 14  
Pastors’ Quotes about the Purpose of Suffering*

Quote 1	Quote 2
<p><i>And I might get very insecure about something, and I live with it. And I’m not trying to get it healed, because it’s like, it’s a thorn in my flesh, if you will. And so I live with it, because I’m saying I’ve got a greater glory. I’ve seen one, in my brokenness I have seen one. I said perhaps one of the things that people are, some of the pastors are saying, you know, it’s like, I’m not going to take the struggle away from you, Paul saying, My grace is sufficient for you. And my strength is made perfect in weakness, and when I’m weak then I’m strong, or he’s strong.</i></p> <p><i>So do we as pastors believe that God gives us all a limp? Can I tell you what I believe?.....That limp will yolk me to a greater dependence on Christ.</i></p>	<p><i>Paul cries out where he has a thorn in his flesh, cries out three times to the Lord and we know the story, you know God doesn’t and then it, the powerful bit at the end is that God’s grace is sufficient, that in my weakness you know He is strong and that so that’s where I land on that in the tension again we’ve got to train our leaders so that they can help our people to learn how to live in the tension, is we love and serve a God who is fully capable to heal, He is sovereign to heal but there are times where He doesn’t and so how do we live in that tension of okay God what are you doing, because it’s intentional and He is at work and it’s for our good and for those around us even when we don’t feel it. I just try and counsel people through that and so we pray for favour, we</i></p>

<p><i>I think deep down we (pastors and Christians) believe those things may be there to drive us to Jesus, and whereas we all want to get physically healed, emotionally healed, spiritually healed, psychologically healed, relationally healed, it's like God seems to, especially amongst leaders, seems to pummel you more and more, and you find greater brokenness. And I don't think we (should) rush toward getting that healed.</i></p>	<p><i>pray expecting God to do something but at the same time we go if He doesn't His grace is sufficient for us uh and that's something people don't want to hear. I think that's the movement of the uh healing movement if I can call it that is booming is because we want to go uh as really like a genie-in-a-bottle like we ask Him to do it and then He'll do it and God is like that's not who I am, I sit on my Throne and I do what I believe is best, because if I do it that will be good for you. And that's just hard for people you know especially if when you saying to someone is "you will have this for the rest of your life", that is just that's difficult to hear.</i></p>
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Having considered the manner in which pastors perceived the role of the field of mental health, one can see how their own framework for understanding mental health begins to be displayed. With much of their interview time spent explaining their frameworks of understanding to me, the inclusion of the next theme is an expansion to this one.

**Theme Two: Point of Departure of Pastors: The Foundational Beliefs that Guide their Interpretations**

When conducting the interviews with the pastors, it was evident that they were intentional and deliberate in their efforts to explain the theoretical beliefs that guided their perceptions and opinions. One of the pastors began the interview by asking me if I had formally studied theology or if my own point of departure was a purely psychological one. Another pastor used the word "Holy Spirit" early in his interview and quickly followed that up by asking me if he was "allowed" to use those words in the interview. Every pastor used a noticeable portion of the interview time to explain, substantiate and even justify the reason for their answers. Each perception that they gave the interviewer was contextualised by giving

information about the details of their beliefs and consequent framework of understanding. Some pastors also assumed that, by nature of the interviewer's faith position, I would have a deeper like-mindedness with their perspective. Pastor C explained it through the analogy of a platform: the theological versus psychological platforms, expressed by contrasting language (what "they believe" versus what "we believe"). This comparison did make room for a common platform, providing the psychological could allow for the theological:

*.. if you had no relationship with the Lord I probably would have be steering this conversation in a different way... trying to first do what I know I need to do as a pastor (to make sure) that you understand (the theological perspective), if you are not on that platform you're never going to understand.....there's never going to be an agreement you know (between Psychology and Theology) - we're always going to have that (lack of agreement).*

*Well I think many psychologists don't even believe in the spirit. So that is difficult ... So for us the supernatural field is real, the demonic activity is real, Jesus dealt with it, we deal with it ... I think decisions in life open up, spreads up to that, so I don't think they are equipped at all, and I don't think they will see it as if they feel it and I don't know even if they believe in it.....*

In essence, the pastors perceived the fields of Psychology (and Psychiatry) to be fields that did not place central importance on spirituality, or on the existence of God. This view was expressed in numerous ways, as shown Figure 3. The pastors generally differentiated between two kinds of Psychology, namely "secular" psychology, and "Christian" psychology. Although there is not a registration category in South Africa for "Christian psychology", the pastors were mostly of the opinion that Christian psychologists practiced a form of Christian psychology by nature of their personal faith beliefs. As indicated in Figure 3, an assumption was commonly made that a mental health professional who professed to be a Christian would generally adhere to a belief in God, in the realm of spirituality, in the infallibility of the word, and the role that sin played in mental health symptomology. Pastor E and G reflected that Christianity was preferable to the profession, but secondary to a high level of competency and ethical integrity, regardless of one's faith beliefs. Pastor A shared a similar view, until asked if he would send his own daughter to a psychologist who was not a Christian. At that point in the interview, he

retracted his earlier statement and conceded that he probably held a subconscious belief that the professional he took his child to would need to be a practising Christian. The conditions under which the pastors were willing to refer a congregant or a family member to a psychologist will be discussed in Theme Three. For purposes of this theme, however, it is necessary to establish the split that pastors made in secular versus Christian psychology, as this informed much of how they explained their foundational beliefs framing their approach to mental health. The pastors took time to elaborate on these beliefs in the interview, because they largely believed that the world of Psychology and Psychiatry refuted or dismissed these foundational beliefs. As noted, however, seven of the pastors stated that the reaction to these foundational beliefs would most likely be expressed differently by “Christian” psychologists, or by “Christian” psychology versus “secular” psychologists or “secular” psychology. The level of disparity, therefore, between the pastors’ foundational beliefs and the acceptance thereof by mental health professionals would be mediated by the extent to which a professional was influenced by “Christian” versus “secular” thinking.

By dividing “secular” from “Christian” psychology, they implied that some of their foundational beliefs might be shared by psychologists who were Christian, which would then be seen more favourably by the pastors. However, when it came to “secular” psychology, the prevailing assumption was that these psychologists would not subscribe to the pastors’ foundational beliefs, which was of great concern to the pastors.

The pastors shared commonalities in their foundational beliefs which included the following seven points:

1. The reality of the existence of God and His ability to work supernaturally (God is ultimately the only true source of healing, although some pastors agreed that God can work through people to aid the healing process).
2. The manner in which sin can be involved with the development of psychological distress.
3. The fact that the spiritual realm exerts an undeniable influence on peoples’ lives, and that subsequently, some manifestations of psychological distress e.g. depression, are spiritual in origin and not psychological (depression can be due to an estranged relationship with God versus a clinical depression). Therefore, the “treatment” that is provided by the mental health field in these cases is misguided and ineffective.

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4. A stable identity is an identity founded in one's identity in Christ.
5. Pastors have a specific spiritual responsibility to take care of their "flock", the congregants under their care. This responsibility is to be taken extremely seriously and includes safe-guarding congregants from counsel that is unbiblical. It also extends to ensuring that their responsibility is not abdicated to an outside professional, but rather that they retain their responsibility to the congregants by a continued involvement in their lives.
6. Christians (and people in general) should take personal accountability for their choices and their behaviour.
7. Some of the core values of Psychology versus Theology differ on a fundamental level at times (for example, divorce and sexuality).

The table below includes some of the pastors' responses that correspond to one another through a similar foundational belief:

*Table 15  
Pastors' Quotes Indicating their Foundational Beliefs*

<b>Quote</b>	<b>Corresponding Foundational Beliefs</b>	<b>Pastors who shared similar views</b>
<i>So God does actually heal people</i>	Foundational Belief 1	A, B, C, D, E, F, G, H, I
<i>(different pastor) As a pastor you'll panic, because our primary thing, maybe you might not enjoy this, but we, we carry this thing of spiritual wellness. Spiritual healing.</i>	Foundational Belief 1	
<i>(different pastor) From a spiritual standpoint what we try and do is leave room for the Divine, let</i>	Foundational Belief 1	

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<p><i>God intervene at any time, He can heal at any time. One must not own the disease, the disorder. So sometimes Psychology can rule out that side completely and then just focus on the natural side of things. We acknowledge the sickness, we acknowledge that there are issues, but we also acknowledge that there is a God that heals and I think we embrace it.</i></p> <p><i>(different pastor)</i></p> <p><i>If the Lord has healed, the Lord has healed</i></p> <p><i>(different pastor)</i></p> <p><i>The psychologist and the psychiatrists...I don't know... because some people have got serious issues, and I know Jesus, if he can raise a dead man, he can heal a serious issue.</i></p>		
<p><i>I do feel like there are times when we have grounds to say it is because of sin, might be in their family, what we call generational curses. There are just some things that are undeniable.</i></p>	<p>Foundational Belief 2 and Foundational Belief 3</p>	<p>Foundational Belief 2 A, B, C, D, E, F, H, I</p>

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<p><i>(different pastor)</i>  <i>Now it's a whole, and I alluded to this, whole different conversation to go okay now that we have acknowledged that (we live in a broken world) and then that person continues (to behave) or does things that perpetuates that sin.....</i>  <i>There is a personal responsibility where I need to take responsibility in how I interact with this broken world.</i></p>	<p>Foundational Belief 2  and  Foundational Belief 6</p>	
<p><i>Whether you are a pastor or you are a psychologist, you are dealing with similar themes. I think of a different solution but the problem is the same.</i></p> <p><i>(different pastor)</i>  <i>So, if I'm feeling a bit depressed, I'm thinking I can deal with that, I'm still alive, and so I don't need help! I need ...</i>  <i>So we tend towards prayer, you know?</i></p> <p><i>(different pastor)</i>  <i>I haven't really met someone (mental health professional) who believes there is a demonic and I think we've put the demonic aside. Kind of thinking dark Africa, and we don't understand what family history does to us and ... so I don't think all family history is emotional, I think some family history is spiritual.</i></p>	<p>Foundational Belief 3</p> <p>Foundational Belief 3</p> <p>Foundational Belief 3</p>	<p>A, B, C, D,  E, F, G, H, I</p>

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<p><i>Alcoholism, I think there is a spiritual realm in alcoholism, I think there is a stronghold in the road of alcoholism. It needs to be broken through prayer.</i></p> <p><i>(different pastor)</i></p> <p><i>There are some things that Psychology can't and shouldn't heal.</i></p>		
<p><i>In Christianity when I'm in Christ, I don't get my identity any longer in e.g. I'm unable to have children. My identity is that I'm a child - a son or a daughter of God. Or if I was into drugs before, my identity is no longer in the fact that uh I'm a druggie, my identity is that I'm I still have to watch that area of my life. And even in terms of things like homosexuality, where there have been guys or girls who have moved out of it, they moved out of it with their identity being in Christ, they still struggle with homosexual with homosexual thoughts, they still struggle in certain aspects of their lives and they will probably struggle with those for the rest of their lives but their, their identity is not there, their identity is here in Christ.....it means helping people discover who they are in Christ...</i></p>	<p>Foundational Belief 4</p>	<p>A, B, D, E, H, I</p>

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<p><i>(different pastor)</i>  <i>There is a mental block that “this is my problem” and this is our view for the rest of my life. Particularly in some types of medication it is like that's - you can see there are some people that embrace this and make this part of their identity. From a spiritual standpoint what we try and do is leave room for the Divine.</i></p> <p><i>(different pastor)</i>  <i>Theologically - that is the basis for our security (in reference to identity).</i></p>	<p>Foundational Belief 4</p> <p>Foundational Belief 4</p>	
<p><i>.....Your journey is important to me and so that's the pastoral.....</i></p> <p><i>(different pastor)</i>  <i>And as much as we are referring people it is not so that we can wash our hands off the whole process but then to work with the person and then there might be things that we don't agree with and we might counsel differently.</i></p> <p><i>(different pastor)</i>  <i>We're scared that people get counselled away from God and in a great sense that's why your pastoral protection will go towards the Great Physician rather than the “great counsellor”.</i></p>	<p>Foundational Belief 5</p> <p>Foundational Belief 5</p> <p>Foundational Belief 5</p>	<p>A, B, C, D, E, F, H</p>

<p><i>We've become like pastors that say go to this one, go to that one, go to our counselling team, and we are not shepherding God's people...</i></p> <p><i>(different pastor)</i></p> <p><i>Almost that we washing out hands of our own sort of like, we outsourcing what we should be doing.</i></p> <p><i>(different pastor)</i></p> <p><i>They (congregants) must feel that you are walking with them, and you are not just abandoning them, also as a shepherd, as a father figure, we like to look at it that way. I don't see the congregation as people that just come to church and we are just here to do the spiritual side of things. We really see ourselves as fathers in their lives so we will be checking up on business, how can we help the whole situation, and walking with people. So as a father figure we don't just do something like that can go in go in any direction, you don't just come to church and pay your tithe, that's not... You are following up with that person even though they might be consulting outside of the church.</i></p>		
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<p><i>and then went to see a particular therapist and that's the route it went!! And that makes me angry and so I would never send somebody to them, that particular therapist for marriage problems...</i></p>		
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It was interesting to note that in relation to Foundational Belief 5, the majority of the pastors said that their congregants asked for their counsel, advice and opinion when looking for a professional to consult. As mentioned, the dominant preference was for a Christian professional, but the question of who that should be was one that congregants mostly posed to their pastors. The latent meaning in some of these discussions pointed to the fact that the pastors, at times, felt as if the congregants were implicitly asking for their consent or approval to see mental health professionals. One of the pastors had formed an extensive network for referral through communicating with other pastors in his area. Three of the pastors were able to refer to two, maximum three, Christian professionals that they personally knew and had history with, but there were four pastors who only had one professional that they felt safe to refer to. This placed those four pastors in a precarious position, because often that specific professional was limited in training, for example, a registered counsellor, when the need was for a psychologist or a psychiatrist. One pastor stated that he would never have the need to refer to a mental health professional, because of his belief that they would be entirely unhelpful. This pastor had referred to general practitioners at times when he felt that a congregant desperately required medication, but these doctors were trained in the same model of pastoral counselling as what he is, and therefore subscribed to the same spiritual beliefs.

The other way that the pastors illustrated their theoretical points of departure was by the quoting of Scripture as mentioned in Theme Two, but also through drawing parallels between their perspective and a biblical example of where this perspective was visible (for example, through the life of Paul, Elijah, King David in Psalms, and Jesus himself). It was during these illustrations that a few of the pastors raised their theology on why suffering takes place. These were thought-provoking discussions for me, because in a theological point of view there is a framework within which to understand the role of an omniscient, omnipotent and omnipresent God in the eventuality of suffering. There is also a theological framework that

allows for comfort in suffering and for a purpose being brought about in that suffering. However, when the pastors considered some of the psychological and philosophical frameworks for these questions of suffering, they seemed underwhelmed by the depth and substance that the psychological frameworks provided in comparison to the theological ones.

From the themes outlines above, the question of how the integration between these two disciplines occurs, begins to become more apparent. Alongside the pastors' acknowledgement (bar one pastor) of the benefit that the field of mental health could offer, and has offered the church, there are also many conditions attached to that potential benefit. This quandary ushers in the third main theme found in the interviews with the pastors.

### **Theme Three: The Integration of Religion, Spirituality and Mental Health: The Two Worlds**

One of the last questions posed to the pastors was twofold: did the pastors desire collaboration with mental health professionals, and if so, what would be the way forward for this collaboration or integration to occur? Of the nine pastors interviewed, eight categorically stated that there was a need for the tension and distance between the two disciplines to be bridged. These eight pastors recognised that the discipline of mental health is required within the context of church and that pastors lack guidance in how to achieve this. That being said, the perceived distance between the two disciplines was one that seemed daunting to them. One of the pastors used an analogy to depict this distance and lack of collaboration, an analogy that captured the essence of what the other pastors were similarly communicating:

*I feel as if we are between worlds now. And we've got bridges and there's links, and we're kind of crisscrossing on ropes, but we're crisscrossing with trepidation and with, you know, a sense of almost... There are bridges linking those **two worlds** but they are still tentative bridges, I feel we're out of our depth, because we're between worlds.*

*And so, because we're in **two worlds**, I don't, we don't speak about it.*

*So it's a big world and I think we're out of our depth, but it would be good to bring the two together with .....so now no longer just the bridge and the thin threads, but with a sort of trapeze dance between the two to begin to emerge.*

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This type of terminology was echoed by other pastors who used words such as, “platforms”, “perspectives”, “different ontologies”, “two camps”, and “two worlds”; which was also used by another pastor. The other pastors made reference to this dynamic by use of analogies or through a more implicit form of communicating. In order for there to be a bringing together of these worlds for greater integration and collaboration, the pastors identified two avenues through which this could take place. The first avenue was the pastor’s role versus the mental health professional’s role in bridging the gap. The second was centred on ways that the disciplines should work alongside one another for the bridging to occur. Both of these will be depicted in tables:

*Table 16*  
*The Role and Responsibility of the Pastor in “Bridging the Gap”*

<b>The Role and Responsibility of the Pastor in “Bridging the Gap”:</b>
- To actively acquire more knowledge about the field of mental health and the benefits it could bring to the church.
- Be open-minded about the field and these potential benefits.
- Create discussions amongst pastoral staff and colleagues around misconceptions that bring disunity in their approach to mental health.
- Similarly, create discussions amongst pastoral staff and colleagues about their protocols in how healing should be dealt with, and when professional assistance is required.
- Discuss mental health issues from the pulpit and with congregants.
- Form relationships with trustworthy mental health professionals so that the fear of there being adverse spiritual outcomes for congregants can be lessened.
- Discover which Christian mental health professionals might be a potential resource to the church and build relationships with these trustworthy professionals so that the fear of there being adverse spiritual outcomes for congregants can be lessened.
- Churches should create safe environments where congregants can more freely share their struggles.
- Pastors should be honest, open and vulnerable about their own personal struggles so that it is normalised within Christian circles.
- Train church leaders within their church contexts to be alert for psychological distress (symptoms).

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<ul style="list-style-type: none"> <li>- Continue to fulfil their main purpose as pastors which includes:             <ul style="list-style-type: none"> <li>• Preach the Word</li> <li>• Pray and trust for healing</li> <li>• Build faith into people</li> <li>• Restore people to their original purpose in Christ</li> <li>• Shepherd God’s people responsibly</li> </ul> </li> </ul>
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*Table 17*

*The Role and Responsibility of the Psychologist in “Bridging the Gap”*

<b>The Role and Responsibility of the Psychologist in “Bridging the Gap”</b>
- Recognise the church and pastors as resources that can join in the holistic treatment of a person.
- Acknowledge the spiritual realm’s significance for congregants and show respect thereof.
- Comprehend that the Christian worldview is most often one that infiltrates every facet of a Christian’s life for example, lifestyle, decisions, choices, and therefore, it should be integrated into the understanding of who a person is.
- Allow for avenues of healing to occur simultaneously with the involvement of both a psychologist/psychiatrist and a pastor.
- Actively recognise and advocate for religious and spiritual beliefs that are healthy and adaptive, and that build resilience in people.
- Provide training and education to church organisations about the field of mental health.
- Create a context in psychotherapy that makes the discussion of religion and spirituality a safe, non-threatening and non-judgemental one.

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There are some correlations between the two tables above, and therefore, a table that looks at shared responsibility for bridging this gap follows:

*Table 18*

*Shared Role and Responsibility of the Pastor and Psychologist in “Bridging the Gap”*

<b>Shared Role and Responsibility of the Pastor and Psychologist:</b>
- Be willing to work collaboratively.
- Reduce levels of ignorance by learning more about the fields.
- Recognise that an all-knowing or arrogant stance is detrimental to collaboration.
- Actively build relationships with one another.
- Perceive one another as equal members of the same team, striving towards a similar end goal.
- Value the ways in which the fields can be of benefit to one another.
- Respect the differences in opinion and approach to healing that are followed by the two disciplines.

Not only did the pastors reflect on the fields of Theology and mental health as being worlds apart (interdisciplinary); they acknowledged the significantly disparate viewpoints between pastors themselves and between various church denominations when it comes to merging these worlds (intradisciplinary). This contrasting dynamic is evidenced in Table 9. Five of the pastors provided examples of arguments amongst their colleagues, or personal experiences of being on the receiving end of criticism for their desire to integrate psychology into the church context. This division had not dissuaded their desire to collaborate, but had most definitely complicated the process considerably.

Although the pastors were eager to form collaborative relationships with professionals, there were some immovable conditions upon which the pastors would feel that collaboration was dependent. As mentioned in Figure 3, the majority of the pastors placed substantial emphasis on the preference for the mental health professional to be a born-again Christian, as this was understood to indicate that the professionals would understand and support the church’s religious and spiritual teachings. This is reflected in the second prerequisite for referral. Of the eight pastors who were willing to enter into such relationships, each one of them mentioned that there would have to be certain prerequisites to referral. The six most represented conditions that were stated by the pastors were the following:

**Conditions for referral from pastors to psychologists:**

1. The pastor and the professional must have a personal relationship spanning over a few years as the main foundation is mutual and profound trust.
2. The professional should be a born-again Christian whose definition of Christianity and doctrine within Christianity is aligned with that of the pastor.
3. It is essential that the professional not only be a Christian, but that the professional possess high levels of competency and displays ethical behaviour.
4. The values, agenda and outcomes of what the professional and pastor want to achieve in assisting the person should be closely aligned, and clearly communicated. The professional's approach to treatment would have to be one that did not contradict fundamental biblical principles that were central to that of the pastor's.
5. The pastor would want to have access to information about the integrity of the professional's personal life. For example, this could include how the professional manages his/her marriage, raises children, and tends to his/her own spiritual growth. This would provide the pastor with evidence about the professional's trustworthiness and character.
6. The professional would have to be open to collaboration with the pastor which would include a respect for and inclusion of his pastoral role within the confinements of confidentiality.

As a further part of the discussion that the pastors had about bridging the gap, and about moving forward, there were three pastors who offered an apology on behalf of their profession for the way that psychologists may have been misrepresented within church contexts, or referred to the fact that this type of occurrence was unhelpful:

1. *An encouragement I want to say - you know we are thankful for men and women like you and what you guys do, and we're in desperate need of more - We desperately need you and your wisdom, your experience, your faith, your commitment, so thank you for all that you do and if you have not felt appreciated by those who are in my camp or in my space then shame on us and we just need to constantly try to figure out how we can do better.*

2. *I think psychologists are being hammered from the pulpit, more as a defence mechanism than a true ... more like a ... I don't know if it is a threat or misunderstanding, so I think that they have taken a hit and ... so they think they are not fairly treated.*
3. *I'm very glad you are doing this study, because it concerns me, both ways, psychologists knocking us and us knocking them. I just feel that's very unhelpful.*

As mentioned in Chapter Two, Section Two, the apologies of these pastors impacted on the interviewer in a very profound way. Having often been on the receiving end of defamatory comments within the church context, I was deeply appreciative of the recognition hereof, and the way it was addressed by these pastors. Many of the pastors similarly acknowledged times when they felt they had been complicit in causing more harm to people who were in distress (either personally, or collectively as a profession, or through the use of lay counsellors that operate within their church context). Examples of this included:

- Preaching the “faith heals” teachings implying that faith and prayer alone are sufficient in dealing with psychological distress or trauma, which included times where congregants were advised to stop using their medication in order to solely trust the Lord for their healing;
- Using diagnostic terms and making assumptions about possible diagnoses without the required training (specifically in reference to lay counsellors);
- Assuming too quickly that someone’s “symptom” is due to a spiritual cause without due consideration of psychological and psychiatric factors;
- Using the name of the Lord, such as the phrase “I feel that God is saying”, in a flippant or negligent manner;
- Creating an atmosphere in which people feel “looked down on” if they have consulted with a psychologist or a psychiatrist;
- The over-emphasis of the role of sin to the detriment of other essential cultural and contextual factors; and
- The sobering realisation that barbaric and inhumane things have been done in the name of religion and in the name of Christianity, for instance, the atrocity of Apartheid within the South African context.

With the mention of how Christianity can be associated with crimes against humanity, the final theme of stigmatisation can be introduced.

### Theme Four: Stigmatisation

For forward movement and effective collaboration to be possible, the (eight) pastors mentioned that certain stigmas would have to be addressed. There were two main categories related to the theme of stigmas. The first one was the way that mental health is stigmatised by Christians or within the church context. The second stigma was associated with the socio-political history of South Africa.

#### Category 4.1: The Stigmatisation of Mental Health by Christians and the Church Context:

To explain the first category, a table of quotes, contexts and latent/manifest meanings follows:

Table 19  
The Stigmatisation of Mental Health Within Christian Contexts

Quote	Context	Latent/Manifest Meaning
1. <i>I know of the Christian culture that sometimes medication can seem like a weakness, it can seem like a lot of, I'm not saying it's particularly in our movement, there is a lot of doctrine that goes around that actually if you're ill, as when you are poor, you must be doing something wrong so there are stigmas attached to that.</i>	Pastor is referring here to the Christian culture that he commonly sees in which those stigmas circulate. He does not perpetuate that in his own church community although he sees that some congregants think in this stigmatised way.	The use of the term Christian culture is one that many pastors referred to. Either in this direct manner, or through implication.
2. <i>We sometimes tend to categorise too quickly, that is demonic, you</i>	“We” is used here to refer to both the pastoral	This statement is one that shows where

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<p><i>need deliverance for that so there is something wrong with you if you are sick and God needs to bring you to a place of healing.</i></p>	<p>fraternity and Christians within the church context.</p>	<p>stigma exists, but the pastor recognises that this is unhelpful at times by saying that it takes place “too quickly”.</p>
<p>3. <i>People feel ostracised, because of what we... unless you're healthy you are not blessed.</i></p>	<p>Often found within the charismatic church circles, but this “unless you’re healthy you are not blessed” stigma is not one that this pastor agrees with.</p>	<p>Similar to the meaning that “something is wrong” seen in other quotes as well.</p>
<p>4. <i>We would refer people to a doctor if they are sick, if there is some issues, trauma, depression, so we should not feeling any way ashamed or unspiritual in referring them to a psychologist to get them to the necessary counselling</i></p>	<p>The parallel is drawn here between the using of medical practitioners versus mental health practitioners. The pastor was commenting in the context that there is often shame or the sense of being unspiritual when referring to mental health professionals.</p>	<p>The words “ashamed” and “unspiritual” are both terms that point to underlying stigmas that are present. This pastor is refuting the accuracy of this stigma, but is commenting on the fact that it exists nonetheless.</p>
<p>5. <i>Or they have disobeyed God if they are going to consult spirits or mediums as the Bible says when they go see a psychologist.</i></p>	<p>This stigma exists within the community where this pastor works; he does not share that opinion, but commented about how frequently he sees it amongst community members and some congregants.</p>	<p>The comparison of a medium to a psychologist implies that consulting with a psychologist would be seen as being as equally spiritually detrimental. The words “disobeyed God” similarly shows the extent to which a</p>

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		community member may feel spiritually condemned if using a mental health professional.
6. <i>I think it's like AIDS, and it is not easy to stand up in a Church and say "I got AIDS" and I don't think it is easy to stand up in a Church and say I had mental health issues. I'm seeing things, or I'm feeling things, you are in a dark hole....</i>	This is in answer to whether or not Christians feel comfortable to speak about mental health struggles within the church setting.	A comparison of divulging one's HIV status to one's mental status is a poignant one. The latent meaning would indicate fear, discomfort, shame and judgment.
7. <i>Because I was brought up I suppose with the same perceptions sort of as everybody else about psychologists. In my bringing up, my culture if I should use that word, psychologists, the certain phrasing that was used.... for psychologists... Uh "mal dokter", "mal dokter gaan sien" and you know 'cause it immediately puts you in a place where you are mad you know. That word was thrown about quite a bit. And so the moment you are referred to someone like that then someone whoever refers you would say "jy's mal!"</i>	This comment refers to the dynamics within the pastor's community and not within his fraternity of pastors.	Equating the need for mental health treatment with being crazy is a stigma that carries a similar theme to "something being wrong with" as seen in Quote 1. The word "maldokter" has connotations that would not endear a community member to seeking mental health assistance due to the judgment of others.

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<p>8. <i>It's still there, it's still very prevalent, you know the fact that that people do not want to see a psychologist, because it puts them in a place where they have no control of their own mind kind of thing you know ya. It's still there in the community. Not amongst my colleagues.</i></p>	<p>This is another example of a differentiation in stigmas that exists within a community setting versus the professional realm of pastors.</p>	<p>This quote is a good example of how a misconception or an ignorance about the field of mental health can lead to the formation of a prevailing stigma that the pastor encounters frequently.</p>
<p>9. <i>I said to them, my parents, recently, why didn't we know about so and so? So it was hidden and frowned upon, and perhaps more so in a context of South Africa Even in a context of our own family, a lot of it was hidden.</i></p> <p><i>I would say it was generally a negative perception and my sort of sense was ooh, like kind of that's not cool, and there must be something very wrong. And so probably very stereotypical South African. It wasn't great and it certainly wasn't celebrated.</i></p>	<p>“So and so” refers here to people that were dealing with depression, or even psychosis. Although this pastor is middle aged, he recently discussed the fact that this was hidden from him as a child by his parents. As mentioned in Theme One, the influence of one’s family of origin plays a significant role in how stigmas are formed. This pastor held similar views to his family of origin.</p>	<p>This quote is another example of “something must be wrong” when someone requires mental health treatment. Of importance is to see how this pastor attributes this particular stigma to a South African perception as a whole. He was implying that South Africa’s history has had an impact on this particular stigma too.</p>
<p>10. <i>We don't know about it and we're a bit ignorant on it, and we are slightly hostile (towards the field of mental health). And it's only now in the last say ten,</i></p>	<p>This is an answer to how the church perceives the field of mental health.</p>	<p>We see here the terms “ignorant” and “hostile” in the church’s attitude towards mental health.</p>

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<p><i>fifteen years as we're exposed to the West more that you find a greater acceptance. But I know we're not where we probably should be.</i></p>		<p>There is the acknowledgement though that there has been a shift in this hostility and ignorance, although there is a way to go before it will be effectively addressed.</p>
<p><i>11. In this community people were a lot more closed (in comparison to his previous church community) so I think it's, there is a cultural aspect to it, uh people uh the wearing of masks and the also the denial.</i></p>	<p>Cultural is used here in terms of the province that he now works in comparison to the province he first worked in. Cultural is also used here to refer to "Christian culture".</p>	<p>"Wearing of masks" and "denial" are both attributed to how Christians approach mental health struggles. It is easier to deny its existence and to function in pretence than it is to speak openly.</p>
<p><i>12. You might find that in congregations that are more prosperity teachers in the sense of health, wealth and where you there's something wrong if you if you're not well.</i></p>	<p>This stigma is seen to exist more in charismatic churches, although this pastor did not agree with the health and wealth teaching. However, he does see its existence in church communities.</p>	<p>"Something wrong" is again the opinion that this is a foundation on which stigmas are built.</p>
<p><i>13. In an urban context, we you know we great at putting on masks and showing up and saying everything's okay, I'm happy and uh and it's only when the bomb explodes that's when we go "oh my goodness, I didn't</i></p>	<p>Silence and pretence is mentioned again in explaining how Christians generally deal with mental health</p>	<p>"Masks" shows the usefulness of hiding one's struggles so that nothing "seems wrong". However, there is a consequence to this which is why the</p>

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<p><i>even know that you were wrestling through that". You know so, I think we need to talk about....</i></p>		<p>pastor has a desire for people to put masks aside so that difficulties can be more easily dealt with.</p>
<p><i>14. I think sometimes we tend to think this is something that is maybe outside of our socio-economic class that like it's uh in the lower income poverty areas but it's I think it's everywhere and it's just well-hidden</i></p>	<p>“This” is the presence of mental health distress.</p>	<p>This quote is another example of how the Pastor was reflecting on how the socio-political history of South Africa has formed prejudiced stigmas.</p>
<p><i>15. There are stigmas that exist where it like, it's well, it's because you have sin in your life you know or you don't have enough faith, and those could be true, and those are legitimate things, but it could also be like, you're not trusting God enough or you're doing, like this is happening, because you, there's ongoing unrepented sin</i></p>	<p>Stigmas are seen to exist within churches but also within the attitudes of some pastors.</p>	<p>The pastor reflects here on a stigma that exists, but he also acknowledges that there may be some truth to this stigma. That being said, he does not subscribe to it wholeheartedly although he allows room for the possibility that these spiritual dynamics could influence mental health.</p>
<p><i>16. In the general wider church I have had quite a feeling of people being looked down on, if they go to psychologists. And the pastors who delve into it too much as being criticised or</i></p>	<p>His answer to how mental health is perceived within churches.</p>	<p>This quote shows the disapproval towards the field of mental health that can be present at times. There is another reference to charismatic</p>

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<p><i>suspect on a fairly wide observation. Sometimes in the charismatic churches I've had the feeling that if you had enough faith you won't need this, so there's a criticism of your faith, which I have hit very strongly with people who are physically ill, so a number of times I've had people in hospital with cancer and someone rocks up and says, if you only have enough faith, you'll be healed. So, that's more on the charismatic side that you get that. On the more conservative, Baptist side, it's just disapproval, the Lord is sufficient, the Word is sufficient, you know those sort of words.</i></p>		<p>churches which seems to link the robustness of faith to the lack of psychological distress. The more conservative churches are understood to be disapproving, but this pastor clearly articulated in this interview that he did not share these stigmas. He has been on the receiving end of some stigmas. Towards the end of the interview, the pastor said that he has seen less of this stigma as the years have gone by, although it is still present.</p>
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From the table above, a trend in stigmatisations can be seen. The presence of mental health difficulties is, at times, stigmatised as an indication that “something is wrong” with the person who is in distress. “Christian culture” exerts a strong effect on how Christians make sense of the interface between Christianity and psychological wellness. This can be observed in how assumptions about one’s lack of faith, spiritual weakness or compromised levels of mental stability are associated with psychological difficulties. This makes people feel ashamed and afraid to share openly, and they often assume that they should rather deal with their pain silently or on a purely spiritual level. People fear the judgment of others and they therefore depend on pretence and the use of masks to hide their internal realities, and to be more “spiritually” accepted.

The socio-political history and context of South Africa may have had an impact on how stigmas are formed and perpetuated. This can be seen by the fact that many of these stigmas are noticed by the pastors within their community settings, but not as frequently in pastoral fraternities. There has been a shift in the extent to which these stigmas permeate thinking, however, they are still prevalent and ought to be addressed more directly for change to continue.

Stigmas are formed on the basis of generalisations, so I would be amiss not to add a disclaimer about the above summary. This summary has been compiled on the basis of the interviews conducted and cannot therefore be assumed to reflect the stigmas of all pastors and all Christians. Further research would be required to test the above summary and its incidence in other churches.

### **Category 4.2: Stigma that is indigenously South African:**

Six of the pastors made specific reference to the context of South Africa and how this has influenced stigmatisation within the church. The majority of them spoke about the “silences” that exist within the church, and how both mental health and the church’s role in Apartheid, racism, and inequality, are mute ones. A pastor said that he had apologised in a sermon to the congregation on behalf of the church for the atrocities that had been committed in the name of Christianity, and that he wanted his church community to be one that actively embraced multiculturalism and equality. Another pastor said that he works mainly in the community setting and that he often hears the phrase “Jesus is the white man’s Jesus”. He has therefore started to pursue studies in the “Africanisation of Christianity” in an effort to make South African Christianity a more accessible one.

One of the pastors relayed a personal experience where he had delivered a presentation at a seminar for pastors from around South Africa. His presentation was based on academic theory, but by means of introducing himself, he shared the context of his church with the delegates. One of the statements made within this introduction was that his church was intentional about being a multicultural congregation. At the end of this address, the delegates were given the opportunity to ask questions. The pastor was asked a myriad of questions, but only one of the questions was based on his presentation. The rest of the questions centred on his introduction and how he copes with multiculturalism in his church:

*It was a very telling thing what happened, because every single question was about my introduction about our church. It's this multicultural stuff and how does it work. It wasn't as if I tried to like make a point, I wasn't all preachy about it, it was just a... you know this is who we are. And it just rattled cages, I thought it was like an innocuous statement like. So I think, I think we have got a lot to do in the whole thing of dealing with multiculturalism and the past.*

Another pastor made a thought-provoking argument that many churches are actually dealing with the collision of mental health stigma with cultural stigma and complexity, which is an area of significant discomfort. He explained that his church context is one in which this collision is palpable:

*Reaching our city..... now that comes with incredible complexity, the more preferences you have in a room you run the danger of turning those into prejudices.... and so you may have a black middle-class educated millennial and they have a whole history and a story and a narrative they're having to now engage with a white middle-class educated person, and so you try, you're trying to navigate through the cultural diversity. How do I even..... like even the way you speak to me and the way you engage with me, whether they're older or younger there's..... how do I speak to an older black African male where culturally it's like well there's places and areas you don't go to now, because of your age and so that becomes a challenge; how do I question his marriage, like it's just, these are places of incredible discomfort. So I think what scares our leaders more is just..... they could take content which is easily accessible and if they were in a context that looks like them, thinks like them, it be easier to navigate through, because then they might go, well some of the struggles that I'm wrestling with I think they're wrestling with as well. When you open that up it's like wow like you know there's a psychological distress that just walked in that I have never experienced and had to engage with that before. It's easier for me to just tap out and go I can't do this.....I think the biggest problem is.... I think our people are just **context illiterate**. And what I mean by that is we now live in uh a South Africa that has changed rapidly in the last few years and the change is happening at a pace that many of us are just struggling to keep up.*

The use of the term “context illiterate” is a powerful one, because it encompasses the immense uneasiness that pastors, and others, face in the interface of culture, multiculturalism and mental health. A full exploration of this was outside the scope of this study, but it is a theme that seems to hold notable meaning and gravity for exploring stigmas that are indigenous to the South African context.

### **Conclusion**

A comprehensive discussion of these findings will be presented in Chapter Six. In concluding this section, I will firstly provide the Thematic Map which was used to integrate the findings into themes, and to organise the themes into a coherent discussion of the pastors’ perceptions. I will then offer some insights about the content included in this chapter. Figure 4: Thematic Map: Pastors’ Findings follows:

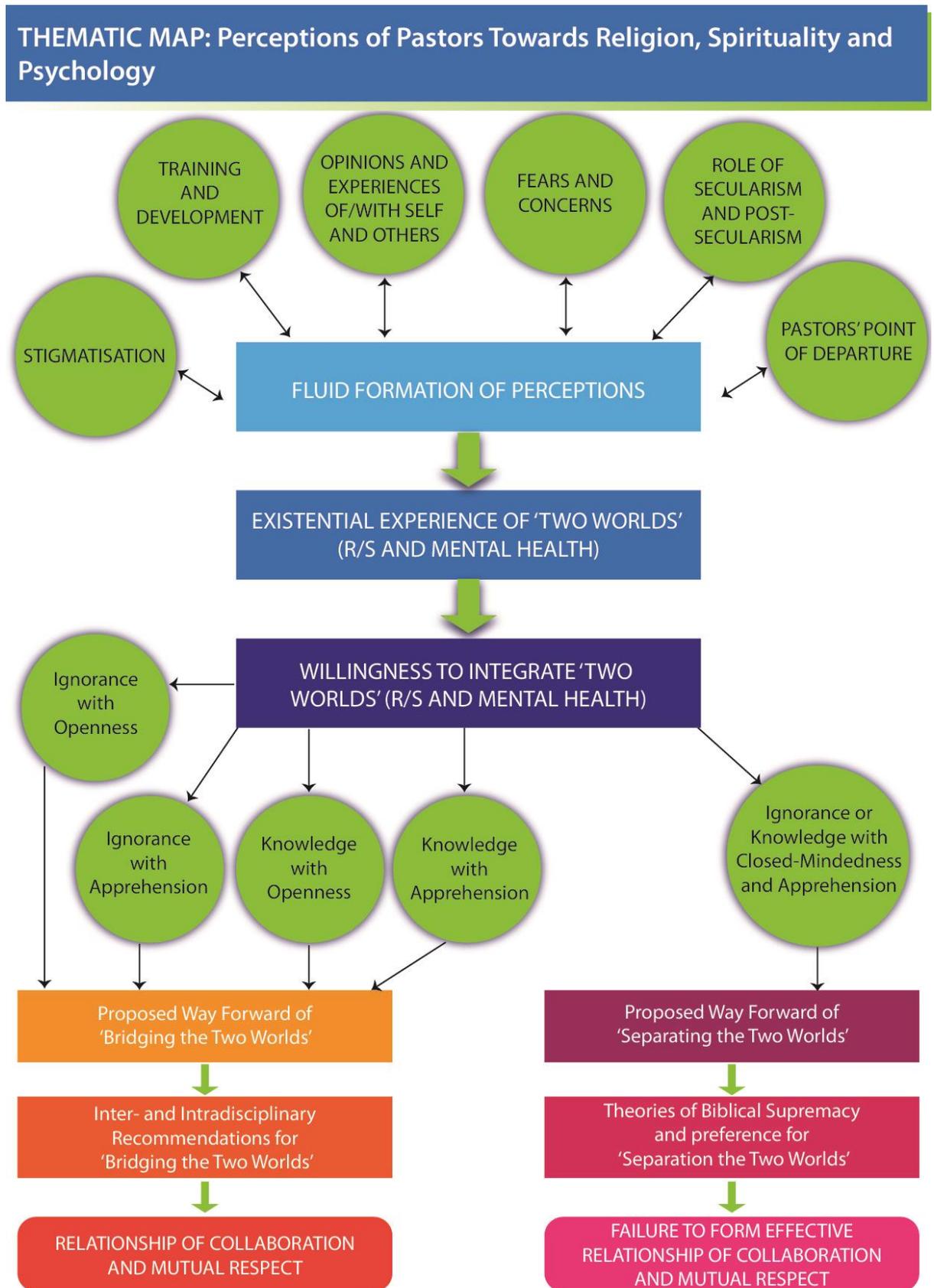


Figure 4: Thematic Map of the Pastors Perceptions Towards Religion, Spirituality and Mental Health

### **Thematic Map Figure 4: Discussion**

As indicated in this thematic map, there are many factors that have contributed to the formation of the pastors' perceptions towards religion, spirituality, and psychology. The perceptions were formed through a myriad of factors, including the pastors' training, their own experiences or the experiences of others with the world of mental health, the pastors' fears and concerns, the impact of secularism and post-secularism on the role of the pastor, the pastors' foundational beliefs, as well as the stigmatisations that the pastors had regarding the interface of religion, spirituality, and mental health. The formation of perceptions, however, is fluid, because it continuously undergoes a process of metamorphosis depending on the experiences that the pastors have within the interface of religion, spirituality and mental health.

With the formation of these perceptions, the majority of pastors expressed the existential experience of the worlds of religion, spirituality and mental health being distinct and different from one another. This is where the key phrase "two worlds" originated, because the pastors saw religion and spirituality as being a different world to the world of mental health.

The pastors' willingness to integrate these two worlds, and to lessen the distance between them was approached with four main attitudes. The pastors described these attitudes in five main ways:

1. Having little knowledge about the world of mental health, desiring more collaboration, and being open to acquiring more knowledge (Ignorance with Openness);
2. Having little knowledge about the world of mental health, desiring more collaboration, but being apprehensive about how to integrate religion, spirituality and mental health (Ignorance with Apprehension);
3. Having knowledge about the world of mental health, desiring more collaboration, and being open to the process of integrating religion, spirituality, and mental health;
4. Having knowledge about the world of mental health, desiring more collaboration, but being apprehensive about how this collaboration and integration would unfold.

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The above 4 attitudes were all ones that resulted in the pastors proposing some ideas and recommendations about how such an integration could be facilitated. These recommendations would result in mutually respectful relationships of collaboration between professionals in the disciplines of religion, spirituality, and mental health.

The fifth attitude towards the integration of the two worlds was as follows:

5. Whether the pastor lacked knowledge, or possessed knowledge about the interface of these disciplines, there was both a closed-mindedness and an apprehension towards collaborative or integrative efforts being developed between religion, spirituality, and mental health (Ignorance or knowledge with closed-mindedness and apprehension).

The pastors that made reference to this fifth attitude proposed that the worlds of religion, spirituality, and mental health remain separated. This was due to the belief of biblical supremacy where the Bible is seen as being the primary resource required in dealing with psychological difficulties, with little to no need for the contribution of the world of mental health. If this attitude was present, then there was no possibility to form effective relationships of collaboration and mutual respect within the disciplines of religion, spirituality, and mental health.

### **Concluding Thoughts about Pastors' Perceptions**

In analysing the data and compiling these four themes, I was struck by the complex way in which perceptions were formed. Theme One was the most detailed theme, because of the way that the pastors described each factor that had moulded their thinking. It was interesting to note times where there was a seeming dichotomy of perceptions present for an individual pastor, with the integration of that dichotomy still in process. There was nothing simplistic about this subject; it was clearly a contentious one that was fraught with various taints. Some of those taints were traumatic, others were harmonious in nature. Although there were many examples provided where a tense and strained relationship was palpable between the two disciplines, there was also an acknowledgment of the potential for reparation. Eight of the pastors reiterated their desire for and commitment to a matrimony of sorts, under specific conditions. These conditions, however, are at times understandable ones if you consider the

acrimonious history that has marred the potential integration. I was also struck by Theme 4.2, which looked at indigenous South African stigmas. This theme reminded me of the penetrative scarring that our history has caused in the lives of South Africans. History informs the present, and in order for true integration to be possible between these two disciplines, an awareness of the socio-political and historical context of South Africa must be fully encompassed.

To conclude this chapter, I will include self-reflexive thoughts to illustrate how this research has impacted me.

### **Conclusion: Reflective Thoughts**

In the light of the qualitative nature of this study, I would like to reflect on the ways in which the interviews impacted me as the researcher. As discussed in Chapter Two, Section Two, one of the impetuses for this research was the dynamic that I experienced as a Christian and as a psychologist in both the spiritual and professional contexts of my life.

The majority of the pastors knew that I am a Christian when I requested an interview, and this was reported to have made them feel more comfortable to agree to it. In each interview, I sensed some discomfort in how they related to me, as if we were speaking two different languages and were seeking a common one with which to communicate. Some of them were apprehensive to give certain answers to my questions out of fear of causing offense. When I realised this, I would reassure them by stating that I wanted their honest and unfiltered perspectives, this seemed to make them feel more at ease.

As a clinician, I gained much insight into how they feel about the field of mental health and their concerns about what we do within the frame of psychotherapy. Some of the points they raised made me carefully evaluate my approach to therapy. In particular, I questioned whether or not I create an environment within therapy where clients feel as if they should abdicate responsibility for their choices and their behaviour. I was forced to reconsider my theoretical point of departure in therapy and to ask myself what I believe about the interface of psychological distress and personal responsibility. Secondly, I felt compassion for how the pastors felt that they are undervalued or marginalised by some mental health professionals. I have had to evaluate my own behaviour towards pastors, and I have to ask myself how pastors should be seen as a resource and as a part of the team when working with Christian clients.

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Their perspective on the framework for suffering was one that evoked much thought and emotion from me. Having been through the loss of a child, as described in (Chapter Two, Section Two) I can relate to the impression that psychology cannot offer the same framework for suffering as what theology can. I have had to consider the possibility that suffering is an area in which theology can provide clients with a spiritual scaffolding that is not replicable through psychology. Although my profession can work effectively with a client through a process of healing from trauma or suffering, I am not convinced that we can answer some of the more spiritually based questions that Christian clients often seem to raise. I will continue to mull over this point as I am not yet sure that I have settled on a solid opinion.

The most challenging moments of this phase of research were the moments when one or two of the pastors voiced their disdain for, or disbelief in the validity of Psychology as a legitimate science. Having previously been in contexts where I have been on the receiving end of overt criticism for my choice of profession, I found myself reminded of those times in some of the interviews. The purpose of qualitative research had to be my grounding and my focus in such times. In this way, I could not “argue”, “defend” or “justify” myself or my profession, my purpose had to be the embedding of myself in the intricacies of the participants’ experiences.

Earlier in this chapter, I quoted a pastor who felt that in my work as a psychologist who was a Christian, I was actually not doing “God’s work” or meeting “God’s mandate” in bringing clients to relationship with God, but that I was making clients “happy” while simultaneously enabling their eternal damnation. This quote was the one that caused the majority of my tumult, because it was directed at me as much as it was directed towards the profession as a whole. The quote contained implications for my own spiritual integrity as well. Although the interview was transcribed within the week following it, I did not begin with the analysis of this interview for a few weeks. In that time, I went for a few supervision sessions with various colleagues so that I could work through my own emotional responses. When I felt as if I had processed my counter-transference, I proceeded with the analysis of the interview.

The interviews with the pastors certainly impacted in both the professional and personal realms. It provided an opportunity for critical analysis and assessment of a multitude of factors. I am grateful that I allowed this phase of the research to generate self-reflection, because it is through this that I have seen personal deliberation and growth.

## **CHAPTER FIVE**

### **FINDINGS: PSYCHOLOGISTS**

#### **Introduction**

In this chapter, I will review the dominant themes that were identified in the data analysis of the psychologists' interviews, the four main themes and the categories within those themes are as follows:

#### **Chapter Outline:**

#### **Theme One: Perceptions of Psychologists Regarding Spirituality and Religion**

Category 1.1: Perceived Definitions of Religion and Spirituality

Category 1.2: Perceptions of the Valence of Religion and Spirituality

- Subcategory 1.2.1. Perceptions of the Detrimental Valence of Religion and Spirituality
  - 1.2.1.1: Rigidity
  - 1.2.1.2: Religiosity
  - 1.2.1.3: Loss of Autonomy
  - 1.2.1.4: Destructive Faith Practices
- Subcategory 1.2.2. Perceptions of the Beneficial Valence of Religion and Spirituality

Category 1.3: Development of Psychologists' Perceptions towards Religion and Spirituality

#### **Theme Two: Point of Departure for Psychologists (Theoretical Frameworks that Guide Their Interpretations)**

Category 2.1: Making Sense of Religion and Spirituality Conceptually

Category 2.2: The Place of Religion and Spirituality in the Client

#### **Theme Three: The Integration of Religion, Spirituality and Mental Health**

Category: 3.1 Approaches to Integration

Category 3.2. Ethics of Integration

Category 3.3. Moving Forward in Integration

- Subcategory 3.3.1 Intradisciplinary Integration
  - 3.3.1.1. Communication and Openness
  - 3.3.1.2 Redressing Stigmatisation and Prejudice
- Subcategory 3.3.2. Interdisciplinary Integration

**Theme Four: Stigmatisation**

Category 4.1.: Stigmatisation by Christians or Within the Church Context

Category 4.2: Stigmatisation that is Indigenously South African?

Category 4.3.: The Way Forward: Redressing Stigmatisation

**Conclusion**

Thematic Map

Concluding Thoughts

The discussion of the identified themes will follow in Chapter Six, where I will consider the findings of both the pastors and the psychologists, and draw conclusions from both sets of data.

### **Theme One: The Perceptions of Psychologists Towards Religion and Spirituality**

The formation of the psychologists' perceptions towards religion and spirituality was influenced by numerous factors. Therefore, the first category will consider what those perceptions were, but Category 2 and Category 3 will review the influencing factors that led to those perceptions. It must also be mentioned from the outset that a distinction in perceptions was often made on the basis of which faith tradition they were referring to. With this study including a specific focus on Christianity, the psychologists were asked to provide comments on Christianity at times, in contrast to a more generalised answer that spans the wide continuum of religion and spirituality. The data showed that faith traditions for example, Christianity, were perceived differently to other faith traditions like Buddhism. In order to capture the distinctions made between faith traditions, I will have to define Christianity or other faith traditions as a separate perception to the generalised comments that the psychologists made.

#### **Category 1.1: Perceived Definitions of Religion and Spirituality**

This category has been titled “perceived” definitions, because the definitions that were offered were not academically based definitions. None of the psychologists read me a definition from an academic source, each of them gave an experiential answer that was more situated in opinion than in academia. I did not specify what type of answer the psychologists were required to give, but I noted that each of them gave an answer that was a personal perception. It is also noticeable that some of the psychologists gave an answer based on how they personally perceive religion and spirituality (R/S) whereas other psychologists based their answers on how they think R/S is perceived by mental health professionals in general.

The table below will summarise the perceptions of both religion and spirituality by each psychologist, not through a direct quote but through a summation of their answers throughout the interview:

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Table 20

*Perceptions of Psychologists Towards Religion and Spirituality*

<b>Psychologist</b>	<b>Perception of Religion</b>	<b>Perception of Spirituality</b>
A	<ul style="list-style-type: none"> <li>- Religion is structured.</li> <li>- It often becomes split off from spirituality with religion being seen as “bad”.</li> <li>- Mind/Body dualism has caused a division in which R/S is not recognised.</li> </ul>	<ul style="list-style-type: none"> <li>- Spirituality represents an experiential sense of something.</li> <li>- Is used to give meaning to people’s experiences.</li> </ul>
B	<ul style="list-style-type: none"> <li>- He has seen that professionals are often apprehensive and fearful about this term “religion”, because it is not seen as favourably as spirituality is.</li> </ul>	<ul style="list-style-type: none"> <li>- It is acceptable and more fashionable than religion.</li> <li>- It is far less threatening to professionals than religion is.</li> </ul>
C	<ul style="list-style-type: none"> <li>- Considering how spirituality is defined by this psychologist, religion would be perceived negatively and associated with an aggressive response by professionals in general.</li> <li>- Religion is more structured than spirituality.</li> </ul>	<ul style="list-style-type: none"> <li>- Spirituality seems to be divided into two main camps, one which refers to God and the second camp which refers to other forms of spirituality.</li> <li>- “God” associated spirituality evokes an aggressive response but the “other” forms of spirituality are not met with aggression.</li> </ul>
D	<ul style="list-style-type: none"> <li>- Religion refers to ideology.</li> </ul>	<ul style="list-style-type: none"> <li>- This term has many meanings but in essence it is the</li> </ul>

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	<ul style="list-style-type: none"> <li>- Sometimes people refer to spirituality in the context of religion.</li> </ul>	<p>capacity to have a belief in something that transcends your existential reality.</p> <ul style="list-style-type: none"> <li>- Spirituality is any belief in relation to one's transcendent reality, including atheism which is also seen as a belief (in the absence of God).</li> </ul>
E	<ul style="list-style-type: none"> <li>- Religion and spirituality overlap but are distinct and separate terms. They can exist together but they do not always do so.</li> <li>- If a person is "very religious" then they are most likely not "very spiritual", because they still adhere to a system of beliefs and encoded practices that give little experience of the sacred. This is described as "sad" by this psychologist.</li> <li>- Religion is a social system of ultimate beliefs, prescriptions, and behaviours.</li> <li>- He sees religion as a "package" of predetermined and fixed ways that one must think about God therefore this narrow way of thinking prevents a person from having a true "spiritual" experience.</li> </ul>	<ul style="list-style-type: none"> <li>- Spirituality is the experience of the sacred which can take many forms.</li> <li>- It is not predetermined or fixed in how it must be experienced.</li> </ul>

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F	<ul style="list-style-type: none"> <li>- Religion and spirituality are separate constructs that both look at the making of meaning.</li> <li>- The term “religiosity” is introduced by this psychologist and defined as a rigid form of interaction with religion.</li> <li>- You cannot be simultaneously religious and spiritual, as religion interferes with genuine transcendence.</li> </ul>	<ul style="list-style-type: none"> <li>- Spirituality is always preferential to a person being stuck in religiosity.</li> <li>- Spirituality is about forming a different connectedness to the world and to the self.</li> </ul>
G	<ul style="list-style-type: none"> <li>- Religion is a formalised system that contains prescriptive ways of seeing the world.</li> <li>- Religion can either support someone in making sense of their lives OR it can play into their interaction with rigidity and inflexibility.</li> <li>- Religiosity is NOT spirituality, religiosity has become difficult to manage, because it is dogmatic.</li> <li>- It has formal criteria about what is deemed to be acceptable versus unacceptable.</li> <li>- It is an internalised personal value system that can at times be at odds with other value systems.</li> </ul>	<ul style="list-style-type: none"> <li>- Spirituality is a sense of self that you bring into the world.</li> <li>- It encompasses values that may be found in religion but these values are not prescriptive.</li> <li>- Spirituality is about finding meaning where you are at, finding peace with the world and with yourself; it is about “being” in the world.</li> </ul>
H	<ul style="list-style-type: none"> <li>- Religion is a formal practice that people adhere and ascribe to.</li> <li>- When religiosity is present then it is less helpful.</li> </ul>	<ul style="list-style-type: none"> <li>- This is an awareness and acknowledgment of something more than the physical realm of life.</li> </ul>

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		<ul style="list-style-type: none"> <li>- If spirituality is not nurtured then it leads to poor physical and mental health.</li> <li>- It is vaguer than religion, more esoteric in nature.</li> </ul>
I	<ul style="list-style-type: none"> <li>- Religion and spirituality are not mutually exclusive.</li> <li>- In religion, there is a following of dogma and a set of well-defined teachings.</li> <li>- Sometimes, church institutions can be flexible in how they allow people to think through the dogma of the specific church.</li> <li>- Religious professionals would most likely say that both religion and spirituality are good.</li> <li>- However, non-religious professionals would say that religion is something to be wary and careful of. This might lead them to reject religion and spirituality altogether, or to be more open to spirituality than religion.</li> </ul>	<ul style="list-style-type: none"> <li>- The term spirituality is a vague one and it lacks a clear definition.</li> <li>- It relates to that part of oneself that wants to explore deeper meanings within oneself, in life, and in the world at large.</li> </ul>

It is clear that the above definitions are not unified in perspective, but there are some commonalities present. Spirituality is generally defined in more positive terms than religion, and in two definitions there is no co-existence allowed for religion and spirituality. Religion has generally been described in ways that emphasise its conformity and its

prescriptiveness for those who follow it. Psychologist E is of the opinion that being “very religious” would prevent one from a transcendent encounter with the sacred, which Psychologist F echoes. The majority of the definitions allow for religion and spirituality to co-exist, although “religiosity” is understood to preclude spirituality. As mentioned, some defined these terms according to their own experiences, while others commented on the collective perceptions of professionals. When reading through this table, a sense of religion being less desirable than spirituality is predominant. This will be considered in the discussion of the data, Chapter Six.

Although misconceptions are evidently present, the purpose of this study is not to highlight possible misconceptions, but rather to form an understanding of what the perceptions are, and how they are formed. Many of these perceptions carry a latent interpretation of the valence of religion and spirituality. The psychologists extrapolated on the valence that they associate with these constructs, which is why a separate category follows where valence can be reviewed.

### **Category 1.2: The Perceptions of the Valence of Religion and Spirituality**

#### **1.2.1: Perceptions of the detrimental valence of religion and spirituality**

There are numerous manners in which religion and spirituality were perceived to be detrimental. The primary ways in which the detrimental valence of religion and spirituality were described will be discussed as subcategories. Many of the subcategories overlap so it is not possible to make each subcategory completely distinct in nature. The subcategories that will be considered are rigidity, religiosity, loss of autonomy, and destructive faith-based practices.

##### ***1.2.1.1 Rigidity***

Each of the psychologists interviewed made reference to religion being associated with rigidity. Some statements were manifest in their meaning, while others contained latent meaning that was interpreted. It was noteworthy to see that although religion in general was associated with rigidity, the psychologists made reference to Christianity specifically when describing the way that rigidity is destructive. Some psychologists linked the word “rigidity” explicitly to Christianity, but not to other religions. The majority of the psychologists defined

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rigidity as being an inflexible and pervasive manner of thinking and behaving that is often governed by a religious institution.

The following table will contain excerpts from the interviews along with the manifest or latent meanings in order to provide context. To ensure confidentiality and anonymity, the psychologists will be referred to as Psychologist A – Psychologist I (Psych. A – Psych. I):

*Table 21  
Psychologists' Perceptions of Christianity*

<b>Psychologist</b>	<b>Response</b>	<b>Meaning Analysis</b>
Psych. A	<i>The deeper you get into them (churches) they expect you to acknowledge, for instance, your beliefs regarding God and who God is and how He works and it becomes very technical and dogmatic at a certain level  In each faith there is so many levels of rigidity and dogmatic beliefs</i>	The word “dogmatic” resounds with a sense of rigidity, because the definition thereof includes the laying down of an incontrovertible truth by an authority figure. Psych. A sees higher levels of dogma within the church context, although he acknowledges that there is an element of dogma and rigidity in all faith traditions.
Psych. C	<i>She said, “Christian - no - she's rigid” I was like how-how do you know? There's an assumption that uh one is rigid so for me it's... it's a horrible thing. There are assumptions about this, as soon as people hear the word Christian....rigid</i>	Psych. C was relaying an event in which a colleague refused an application of a Masters student, because the student mentioned that they were Christian. The colleague’s response showed how the automatic assumption was made that she would be rigid. Psych. C sees this as a “horrible”

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		assumption and points out that rigidity is associated with Christianity specifically.
Psych. D	<i>I definitely think that's how most people think about it, Christianity and rigidity. That's where people go when they think Christianity, they go to the extreme examples of rigidity. And there are more than enough examples of that. I think it is reflective of our interpretation of the beliefs, but I don't think it is necessarily reflective of the faith system</i>	Psych. D thinks that rigidity is linked to Christianity due to the extreme examples that are available to illustrate this association. However, he differentiates his own perspective from the general perspective by saying that this association is not necessarily accurate, but is based on how people (in academia) interpret Christianity.
Psych. E	<i>You know here's the package, you got to think of God in these fixed terms so I think a lot of the time those fixed notions of religion actually stop people from having spiritual experiences. A person firmly holds to that I mean I have no right to violate and say "what's this" and "you can't believe that". I would see it (fixed notions) as restrictive and I would hope that we might have the opportunity to open it up. Sometimes you do and sometimes you don't.</i>	Rigidity is seen by Psych. E as the requirement to think about God in fixed and immovable ways. This form of rigidity is interpreted by him as being one that prevents access to spiritual experiences. Although Psych. E would see the rigid belief as being restrictive, this would not lead to a direct confrontation of the belief. Psych. E would, however, look for an opportunity to shift this belief in the client.

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<p>Psych. F</p>	<p><i>.....yes well like you would with anything that a patient will bring that seems very fixed and certain.....</i></p>	<p>This psychologist was referring to an objective to inquire about beliefs in a patient's life that seem fixed, even if those beliefs pertained to religion. Psych. F comments later in the interview that he would not confront religious beliefs out of respect for the patient, but that an inquiry would definitely ensue so that the psychologist could understand the application of these fixed beliefs more fully.</p>
<p>Psych. G</p>	<p><i>....ways in which their own struggles of rigidity and flexibility play into their experience of religion....</i> <i>I struggle with rigidity. I really, really struggle with rigidity</i></p>	<p>Psych. G differentiated between two ways that religion can be expressed by a client. Either it is expressed in an adaptive way, or its incumbent beliefs are seen as rigid and inflexible truths to which the client adheres unwaveringly.</p> <p>Psych. G was forthright and honest in saying that he has high levels of countertransference when it comes to rigidity, both in the religious and political arena.</p>

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Psych. H	<i>....because the religion is known for that it may be seen as a rigidity issue.....</i>	The religion that Psych. H is referring to is Christianity. The statement is responding to the idea that Christianity can be associated with fundamentalism, rigidity, or proselytisation. Psych. H elaborated that Christianity can be known within professional contexts as fundamentalist, which may be due to its rigidity.
Psych. I	<i>I have worked with patients at times where I have felt that if it's a very rigid religion it's holding the person back in some way. So it's the rigidity rather than the faith itself, it will be the connection of religion and spirituality, which I see as different by the way</i>	Psych. I has had first-hand experience of religion being used in a rigid manner, and therefore holding someone back. The disclaimer is made, however, that it is not necessarily the faith itself that is rigid, but rather how the faith is expressed. Psych. I further stipulated that religion and spirituality are separate constructs which are to be viewed separately.

Although rigidity was more often associated with Christianity than not, the psychologists were able to recognise that this was mostly a generalisation. The fact remains, however, that in this study the predominant association that is linked to Christianity is one of rigidity. This will be expanded on in Theme Four when stigmatisation is discussed. One of the words that was used often in the discussion around religion was the word religiosity. Therefore,

the next subcategory will consider the use of “religiosity” as a term associated with the valence of religion and spirituality.

### ***1.2.1.2 Religiosity***

Although none of the psychologists referred to the academic definition of religiosity in their responses, a few of them offered perceptions of the valence of religion and spirituality based on the level of religiosity present in an individual. In the majority of responses, religiosity was perceived to be a factor that diminished the valence of religion:

*Response 1: I think around the religiosity when I, certainly in my experience the religiosity has.... as a trainer in practice that sometimes has been a little harder to manage....religions they would say that you know sometimes you need to be firm, set harsh discipline or that sort of thing*

*Response 2: So if your religion..... your religiosity hangs loose like...it's not integrated, it is not part of the whole of you and functions not as a seamless part of you. It stands out for some reason...it's not helpful*

*Response 3: The challenge is that you need to find an organisation, church body that is more aligned with your sense of self. Because I think it becomes harmful when that is not there. You know, then you are like putting a triangle in a square hole and I think there is a lot of that especially it's more sort of religiosity like thing...*

*Response 4: Remember also part of psychosis is religiosity where they borrowing from religion to explain their stuff that's going on, you know, so the person might say you know “I am Christ, I have this power to do this thing” so they taking from the, what we term religiosity*

Response 1 and 4 both link religiosity to more pathological representations, such as harsh discipline, or a manifestation in psychosis. Response 3 implies that religiosity contains rigid parameters within which one must adhere, while Response 2 still uses the word “if” to denote that religiosity is not always seen to be something that is necessarily unintegrated. Out of those four responses, three of them imply that religiosity is more maladaptive than it is adaptive. Perhaps this demonstrates that religiosity, religion and spirituality are not well

understood within the academic context, and that there is not a standardised framework with which to conceptualise these terms. This will be discussed more thoroughly in Theme Three.

### *1.2.1.3 Loss of Autonomy*

The loss of autonomy that results when a person is embedded in their religious beliefs was referred to by 5 psychologists, either, because the psychologist associated religion with a loss of autonomy in their clients, or, because the psychologists themselves had been on the receiving end of this assumption because of their own personal religious beliefs:

*Response 1: I've seen people who have come to me and say but in the morning I open the Bible and then the answer is there in that passage..... and sometimes with very serious consequences.....and I then go later in the day and I sign my children off .....they can now immigrate to wherever, because then it has become a thing unto itself where the person must give up all autonomy..... highly intelligent people not using all of the...everything that they have been given*

*Response 2: I think that there are people who are very religious but I don't think they are spiritual. They've bought into a system of beliefs and coded practice but they've had very little direct experience of the sacred. I mean those are the people who are quite sad for me. People who have grown up with religious systems who are very codified, they have to follow laws, if you don't behave in a particular way you're going to go to hell, but there's very little real experience around....there's very little sense of spirituality. It's participating in a social community and say for example going to church, having particular beliefs that form a moral code, but there's very little direct experience of the sacred*

*Response 3: I think in terms of Christianity there is, I think a reaction to the request that you suspend an agency to some extent, you know, there's belief in a Saviour and there's a belief in deliverance and you know, all of those things, and the miraculous and there's a lot that's unexplained. And I think there's a reaction to that, but I think the reaction to Christianity has been not keep track with how practice has evolved*

Responses 1, 2 and 3 seem to refer to a loss of autonomy by subscribing to religious beliefs. The psychologist in Response 1 gave two examples of clients who had been seen in private practice and who were assumed to have surrendered autonomy of thought by opening the Bible and looking for a Scripture to guide their decision-making. The psychologist makes

the statement that these are “highly intelligent people not using what they have been given”, which refers to the clients’ failure not to make intelligent decisions in the context of their religious beliefs. In this sense, the psychologist sees religion as being detrimental in its requirement for autonomy to be surrendered.

In Response 2, there is latent meaning in the sentence “*people who have grown up with religious systems who are very codified, they have to follow laws, if you don’t behave in a particular way you’re going to hell*”. The latent meaning of “codified” was confirmed with the psychologist during the interview to relate to a loss of personal agency/autonomy. This “codified” process was seen by the psychologist in people who have grown up in religious systems. In religious systems, there has been indoctrination into believing particular precepts, and then adhering to behaviour that is required. The psychologist views this “codification” as being “sad” and as usurping any experience of the sacred.

Response 3 shows a distinction between what the psychologist views as the common assumption amongst his colleagues, versus his own personal opinion. He states that Christianity, in particular, is often assumed to be a religion where personal agency is suspended, because of a belief in the supernatural realm. His opinion is that psychologists react negatively to that suspension, but that this is not necessarily reflective of how Christianity has modernised, or how it operates in contemporary society. With this comment, the latent meaning reveals his dubiousness about the validity of the more generalised assumption mentioned.

It is obvious that all three of the above responses refer either directly or indirectly to the Christian faith. The question arises then of whether the loss of autonomy is viewed to be primarily present in Christianity, or similarly in other faiths; the investigation of which was outside the scope of this study.

Some of the psychologists commented on loss of autonomy by sharing examples of where they had been on the receiving end of this dynamic, or where they had heard this opinion being shared within professional contexts:

*Response 4: There’s almost a sense of “if you’re still a Christian after all this, you haven’t yet woken up”.*

*Response 5: People seem to think you’re an idiot that you’re a Christian in order to be a Christian you have to be an idiot.*

*Response 6: You you get dismissed almost like you're - I don't know a flake or something.....*

Responses 5 and 6 were made by the same psychologist, Response 5 being in relation to how Christianity has been perceived within the psychologist’s professional context, and Response 6 was in relation to the judgment that the psychologist has received concerning personal faith convictions. The psychologist who gave Responses 5 and 6 is a Christian. The psychologist who gave Response 4 is atheist and made this statement in connection with how Christianity is generally perceived by professionals in the department where she is employed.

All three responses tap into a loss of autonomy with the use of language such as “you haven’t woken up”, “you are an idiot if you are a Christian”, and that Christians are dismissed as being “flakes”. Those terms do not indicate an opinion that Christianity is associated with autonomous thought or behaviour. Therefore, the valence of Christianity is negatively affected when seen as a contributing factor for the loss of personal agency or autonomy.

**1.2.1.4 Destructive faith practices**

Almost all of the psychologists interviewed referenced experiences of faith-based people engaging in practices that they felt had adversely affected their clients. This was one of the main contributors to the formation of negative perceptions about the valence of religion and spirituality. The table below gives a summary of the most frequent examples given of destructive faith practices along with the psychologists who mentioned them.

*Table 22  
Psychologists’ Perceptions of Detrimental Faith Practices*

<b>Destructive Faith Practices</b>	<b>Mentioned By Psychologists</b>
- Instructing people to stop taking their psychotropic medication	A, B, C, D, E, F, G, H, I
- Encouraging people to trust solely in the healing power of God rather than receiving treatment from mental health professionals (faith heals teaching)	A, B, C, D, E, F, G, H, I

- Making statements within public or personal contexts that stigmatise mental health difficulties and the field of mental health	B, D, F, H, I
- Informing clients or their families that a process of deliverance must be conducted in order for a patient to recover	B, F, H, I
- Advocating for family systems that are patriarchal or overly authoritarian in nature	A, F, G, I

All of these examples were seen by the psychologists to be disruptive and interruptive for treatment processes. In some cases, the psychologists felt that the client or patient deteriorated in functioning after they had been exposed to these religious or spiritually based interventions. There were a few times, however, when clients had received prayer from the pastors but had not been told to change anything in their treatment protocols. The psychologists identified these occasions as constructive ones for their clients.

### 1.2.2: Perceptions of the Beneficial Valence of Religion and Spirituality

Of the nine psychologists interviewed, five of them were able to report specific ways in which they think that integrating religion and spirituality is valuable or beneficial. However, all nine of the psychologists made some form of reference to the fact that religious institutions can be a source of support for clients. Although the context that their perception of valence was formed in was not articulated in the interview, the psychologists tended to answer according to the benefits that they had seen for clients, rather than for themselves personally.

The majority commented on the church being a positive source of support for clients as indicated in the below quotes:

*Response 1: My practical experience in working with clients or patients is that religion tends to play a positive part in their lives*

*Response 2: I see it more regularly as helpful. It's no, I say it's 90% of the time. It is often a very strong and a positive binding force for many human beings I think it's very important uh and it's helpful*

*Response 3: I would ask - what's your sources of support? And God would be one of them*

*Response 4: Interviewer: Do you have examples of instances in which the church you feel has been a helpful part of the person's life?*

*Psychologist: I know that my answer is yes and I am trying to think of an example (the psychologist was not able to give an example but still emphasized that there have been times when the church has been helpful)*

*Response 5: I see that (destructive influence) less often than I see people actually finding support within the church or their religious or spiritual community.*

One of the psychologists felt that the church was specifically beneficial in how it builds resilience in people through the imposed structure. A similar opinion was shared by another psychologist's perception that the rigidity that is found in church systems can be internalised in the positive sense of providing a client with a fixed point of reference:

*Psych. D: I think you cannot look at resilience without recognising the role of religious belief in coping, you know, so absolutely that's important, and I think there's definitely been times when church as an institution has been helpful. You know, with rigidity, with structure, you know sometimes that's what's lacking internally. And then the external structure is useful.*

*Psych. F: That so-called rigidity is very good - for some people it's healing. So it depends on the person in front of you.... and uh so almost like a wild adolescent who needs to have some fixed points of reference that means she can cling to relate to - that religious rigidity - I don't call it rigidity (in this specific case)... is very, very important and healthy and necessary and I can tell you in many cases I don't know where people would have been had it not been for that. They'd be more lost, more afflicted, more ill for a longer period of time.*

Although rigidity is associated with detrimental valence in Section 1.2.1, there are times when the perception of valence would shift. Rigidity is seen by both the above psychologists as being beneficial to clients when there is a need for adaptive rigidity. It would appear, then, that rigidity in itself is not viewed to be detrimental by the psychologists in the above responses, but that the use of rigidity determines its valence.

**Category 1.3: Development of the Perceptions of Psychologists towards Religion and Spirituality**

There were a number of factors that influenced how the psychologists had formed their perceptions about religion and spirituality. Some of their perceptions were specific to Christianity while other perceptions spanned across all religions. The table below lists the most commonly reported influencing factors in order of most to least frequently mentioned:

*Table 23  
Factors Influencing the Development of Psychologists’ Perceptions*

<b>Factors Influencing the Development of Psychologists’ Perceptions</b>
1. Personal worldview and cultural understanding of religion and spirituality
2. Personal religious and spiritual beliefs
3. Family of origin, including personal socio-political history
4. Clinical experience with clients in private practice and with patients in hospital settings
5. Formal training (undergraduate and graduate)
6. Departmental approach to religion and spirituality
7. Experiences with colleagues

The extent to which these above factors had contributed to the formation of the psychologists’ perceptions was expressed by them in how they explained the theoretical framework that guides their clinical practice. Theme Two will review the psychologists’ theoretical points of departure and the manner in which the above factors have been translated into practice.

### **Theme Two: Point of Departure of Psychologists**

This category has been titled “point of departure”, because it refers to the theoretical frameworks that the psychologists use when making sense of the psychological symptoms of clients/patients, and when determining the treatment that will be given to clients/patients. The theoretical frameworks that the psychologists use had a substantial influence on their understanding the interface of religion, spirituality and mental health.

#### **Category 2.1: Making sense of religion and spirituality conceptually**

One of the primary ways in which the psychologists made sense of religion and spirituality was through the theoretical frameworks to which they each subscribed. Each of the psychologists explained the theoretical frameworks that they use in psychotherapy and how religion and spirituality is referred to within that framework.

Three main theoretical frameworks that were most frequently referred to by the psychologists when explaining where religion and spirituality is incorporated were:

1. Existentialism/Phenomenological (used interchangeably by participants)
2. Systems Theory/Person-in-Context (equal frequency)
3. Object Relations

This was not reflective, however, of the theoretical schools that the psychologists necessarily subscribed to. Even though some of them referred to the value of existentialism within the understanding of religion and spirituality, some of them were still advocates of, for example, an object relations framework. There was a variety of such theoretical frameworks followed by the psychologists and these are listed below with the number of psychologists who fell into that particular framework:

1. Existentialism (Phenomenological): 3
2. Systems Theory/Person-in-Context: 3
3. Object Relations (or Object relations integrated with other theories): 3

Even though the psychologists did not all follow an existential approach, many of them made reference to existential principles as being an effective way to understand how clients form meaning in their lives. This was also true of the person-in-context terminology that was often used to illustrate how clients must be understood culturally, which includes

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religious and spiritual beliefs. Four of the psychologists stated that the biopsychosocial-spiritual model is an example of a theoretical framework that allows for a client to be understood more holistically.

The table below includes some of the statements provided by the psychologists about the three main frameworks used and how these have guided their opinions about R/S:

*Table 24*  
*Theoretical Frameworks Followed by Psychologists*

<b>Theoretical Framework Followed</b>	<b>Quote from Psychologists Regarding Theoretical Framework Followed</b>
Existentialism/Phenomenology	<ol style="list-style-type: none"> <li>1. <i>In the clinical practice though I work from a very existentially orientated in psychotherapy so that means that I work with a client's world view with a full acknowledgement and recognition of my own world view. I do explore spirituality with patients as I believe it is part and parcel of who we are as human beings</i></li> <li>2. <i>I think it's hard to deal with those issues (in clients) if you haven't faced for yourself what those existential and spiritual experiences are about</i></li> <li>3. <i>Religiosity and spirituality is all about meaning - also making meaning, finding answers.</i></li> <li>4. <i>The existential aspect....unless you understand that then you're not going to be able to meet the need of that person</i></li> </ol>
Systems Theory/Person-in-Context	<ol style="list-style-type: none"> <li>1. <i>I find it hard to be dualistic, because it's my thinking, it is the person in front of me I see the person as a whole person and there's a context, there's a spiritual context there's a family context, there's</i></li> </ol>

	<p><i>an intra-psychic context so when I look at somebody I see a whole person. I don't see somebody with only a mental illness. I find it hard to think in terms of mental disorders. So it's a person. And I think more systemically and holistically, that was also my training so that I think that's my mindset, right from the beginning - systemic. Ya so... and I will work with whatever the client is presenting</i></p> <p><i>2. The person-in-context - who are they, what are their beliefs, culturally and other spiritual belief systems and things like that</i></p> <p><i>3. It's impossible to function without a kind of spiritual base and on the other hand I also think their spirituality can't work without a psychological base, because they intertwine. It's a person in context.</i></p>
<p>Object Relations</p>	<p><i>1. I have a strong connection with certain psychodynamic thinking, more specifically in an object relations way of thinking that they ... we are first and foremost relational and that we make choices and that we through these choices might either act in ways that strengthen relationships, or act in ways that disappoint and undermine relationship. So much of how God and Deity, and religion is, is constructed gets replicated general object relations and how they view the world and how they interact</i></p>

	<p>2. <i>You need to go through the experience first through your own analysis and then through supervision with analysis. If you haven't been through that you then going to go and use formula out of textbooks (in understanding what clients bring to the room, including R/S)</i></p> <p>3. <i>My view on therapy or working with people is anyway that it's about mother, father and God. That's all, that's what therapy is about and god then, not necessarily the Christian God but the god-concept</i></p>
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Part of the research question when formulating the research proposal for this study was to identify the theoretical frameworks that allow for a holistic understanding of clients, which is inclusive of their religious and spiritual beliefs. From the responses in Table 24 above, it would appear as if these three frameworks provide this type of understanding. The application of how the theoretical frameworks impacts the psychologists' perceptions of the role of religion and spirituality will be discussed in Category 2.2 below.

**Category 2.2: The place of religion and spirituality in the client**

Linked to the theoretical frameworks that the psychologists use is the way that these frameworks situate the importance of religion and spirituality within the client. It must be mentioned that the psychologists' theoretical framework was not the only factor that influenced this perspective, it was also influenced by other factors which were mentioned in Table 23 where we considered what affected the development of psychologists' perspectives. For example, one of the psychologists views the place of religion and spirituality in the client as being of essential importance, but this is more due to his own worldview than being informed by his theoretical framework:

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*I'm a Christian - so uh my whole uh worldview, view of life and what I do and govern is in terms of my religious beliefs um and so the way I function, the way I apply anything whether it's interpersonal relationships, uh morals, values it's all rooted in my beliefs you know, so ya, you know and then therefore the whole concept of spirituality like the way I described will be strongly rooted then in belief of and uh I mean that infiltrates your whole attitude and view of things.*

Although the data showed that the psychologists varied in their opinions about religion and spirituality, there was one concept that they were unanimously in agreement about. This was the fact that religion and spirituality can be an exceptionally central part of clients' lives, that it can affect how they think and behave, that it cannot be excluded from a holistic understanding of how the client functions, and how symptoms are assessed or treated. Table 25 below includes excerpts from each psychologist's interview to demonstrate this point of departure about the role of religion and spirituality for a client. The context column of this table will be used to provide the context of the quote where necessary. Unless otherwise specified, most of these answers were in response to the question of how religion, spirituality and psychology interface for a client. The context column will also be used to highlight important words or phrases that will be commented on in the paragraphs following this table:

*Table 25  
Psychologists' Perceptions of the Role of Religion and Spirituality for Clients*

<b>Psychologist</b>	<b>Response Given</b>	<b>Context</b>
Psych. A	<i>1. And if you look at the world at large, the vast majority belong to some kind of religion, have affiliated themselves with religion. I mean it's even on most forms you complete whether you go where or whatever you do there's a section on religion. It is such a fundamental part of who we are and then obviously from an existential perspective it has such a big impact on your world and how you structure your life, how you view pathology,</i>	<ul style="list-style-type: none"> <li>- Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living.</li> <li>- Religion and spirituality form a framework with which people</li> </ul>

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	<p><i>how you view life's difficulties, how you view the outcome or the relief of the or the solution to all those difficulties</i></p> <p>2. <i>I mean it's a massive part of our population's functioning so therefore I mean even if we ignore it academically it won't go away. It is there it will be part of your client's life world experience. I would say then rather embrace that and explore that as you would other parts of their functioning.</i></p>	<p>construct meaning in their lives.</p> <ul style="list-style-type: none"> <li>- This is an interesting point, that by ignoring religious and spiritual themes in psychology, they do not disappear. It is therefore more valuable to integrate them into the process.</li> </ul>
Psych. B	<p>1. <i>We cannot separate religion or religious beliefs or spirituality from how a person functions. And as psychologists we are interested in behaviour, we are interested in functioning and healthy functioning. We normally look at behaviour, we look at thought patterns, we look at emotional functioning but we leave out religious functioning, or we have decided that this is something that we should not address, we should not study or include and I have decided that it.... we cannot leave it out. If we really want to look at mental health, why ignore such a very important aspect of a person's functioning like religious beliefs or spirituality? It does affect how a person views the world, it</i></p>	<ul style="list-style-type: none"> <li>- Repeated Theme: Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living.</li> <li>- To understand the nature, assessment and treatment of mental health dynamics holistically, a psychologist must consider the way in which religion and spirituality</li> </ul>

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	<i>does affect how a person views health or illness, it does affect how a person views how to heal, how to recover</i>	interfaces with mental health.
Psych. C	<ol style="list-style-type: none"> <li>1. <i>I mean if you're taking like a person-centered approach, you have to, because you have to take this person as they are, so some schools of thought uh are more open or accepting and others are kind of quite hard actually - hard on you if you dare to express any spiritual aspect to you</i></li> <li>2. <i>I do think that most things have spiritual aspects to it how one responds for example to the loss</i></li> <li>3. <i>Spirituality and religion, it matters, it matters big-time whether you actually hold on to these things</i></li> </ol>	<ul style="list-style-type: none"> <li>- A person-centered approach embodies the consideration of the whole person.</li> <li>- Some theoretical points of departure are more open to the consideration of R/S than others.</li> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a framework with which people construct meaning in their lives.</li> <li>- Repeated Theme:</li> <li>- Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living.</li> </ul>
Psych. D	<ol style="list-style-type: none"> <li>1. <i>I think they belong together, I think that Psychology in essence is</i></li> </ol>	<ul style="list-style-type: none"> <li>- It is not possible to consider psychological</li> </ul>

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	<p><i>theological. The one cannot exist without the other.</i></p>	<p>functioning without an analysis of the R/S factors that may be influencing this functioning.</p> <ul style="list-style-type: none"> <li>- The interface of religion, spirituality and psychology is inseparable and overlapping</li> </ul> <p>Note: Psych. D and Psych. E were the only two psychologists who specifically voiced an opinion that many psychological constructs are actually spiritual in nature</p>
<p>Psych. E</p>	<p><i>1. One is always walking this path between a religious belief and psychological moment. (For example), In depression we ask what the meaning of life is and that becomes a spiritual issue. There's a reason you've got depressed, there's a meaning to this, we need to start the process of understanding what the meaning of this depression is. And that's implicitly a spiritual question.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- The interface of religion, spirituality and psychology is inseparable and overlapping.</li> <li>- Repeated Theme:</li> <li>- It is not possible to consider psychological functioning without an analysis of the</li> </ul>

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		<p>R/S factors that may be influencing this functioning</p> <ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a framework with which people construct meaning in their lives</li> </ul>
<p>Psych. F</p>	<ol style="list-style-type: none"> <li>1. <i>Look at our bio-psycho-social model, they then added the other "s" they now call the spiritual...as if it is now a new thing recently, but I mean it's been there forever and it's always a part of any human being that sits in front of you. As we intimated earlier the breadth and depth is massive and for each person it has a different location in their world. It's located in a different way that means different things</i></li> <li>2. <i>A Mom sits in church, we hear it (in the womb) already, so it's just there from forever, it's per... it's pervasive</i></li> <li>3. <i>It has a very real impact on their mental health and on their presentation, psychological health or psychological distress</i></li> </ol>	<ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- The interface of religion, spirituality and psychology is one that is inseparable and overlapping.</li> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a framework with which people construct meaning in their lives.</li> <li>- Repeated Theme:</li> <li>- It is not possible to consider psychological functioning without</li> </ul>

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		<p>an analysis of the R/S factors that may be influencing this functioning.</p> <p>Note: Psych. F was the only psychologist that made reference to how religion and spirituality may impact on a person from the time that they begin to develop within the womb.</p>
Psych. G	<p><i>1. I think religion plays a huge role in people making meaning in their lives.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living.</li> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a framework with which people construct meaning in their lives.</li> </ul>
Psych. H	<p><i>1. My whole uh worldview, view of life and what I do and govern is in terms of my religious beliefs um and so the way I function, the way I apply anything whether it's interpersonal</i></p>	<ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a framework with which people</li> </ul>

	<p><i>relationships, uh morals, values it's all rooted in my beliefs you know, and then therefore the whole concept of spirituality like the way I described, we will be strongly rooted then in a belief of God and um and a particular view of God. If you're coming from a Christian perspective God that is merciful, full of grace, loving so and uh I mean that infiltrates your whole attitude and view of things.</i></p> <p><i>In my practice uh particularly with black African, South Africans, spirituality plays major role. Eighty percent of black people uh are Christian anyway even if they practice a dualistic African belief so it plays a very important role. So those things infiltrate through all the time, in therapy, in.. even the understanding of illness</i></p> <p><i>2. I mean working with a multi-disciplinary team uh we see that (the importance of religion and spirituality) all the time uh and it can vary, because if I just give you some examples ok so for instance if you look at this um before we have a ward round in the morning, the nurses will have patients ready, it will start with prayer, it will start with singing, very often it's hymns and choruses. It's because most nurses come from a kind of Christian belief so you'll hear this in the ward,</i></p>	<p>construct meaning in their lives.</p> <ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living.</li> </ul> <ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- It is not possible to consider psychological functioning without an analysis of the R/S factors that may be influencing this functioning</li> </ul>
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	<p><i>in the kind of unit and then um you'll have your ward round. Now in the ward round, very often these beliefs will come through so the nurse practitioners will explain and say well this is what the family have felt, this is what the patient have been talking about you know they've not done this, they want to take the person to church and pray, sometimes for a pastor to come in to pray and things. So the multi-disciplinary team is very aware and sometimes tolerant, sometimes intolerant, because sometimes what happens is uh depending particularly the ultra-Pentecostal groups they have come in.....(discusses examples in which church groups have been unhelpful)</i></p>	
<p>Psych. I</p>	<p><i>1. I think you know there is a recognition that we are, whichever part of our society you look at, we are generally really a very conservative society and religion is very central to many peoples' lives. We seem to collect communities around religion, around faith it's often the primary grouping that many people belong to. In fact, you know, I remember many years when we first moved into this house a neighbour came over and introduced himself and his second question was</i></p>	<ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- It is not possible to consider psychological functioning without an analysis of the R/S factors that may be influencing this functioning.</li> <li>- Repeated Theme:</li> <li>- Religion and spirituality form a</li> </ul>

	<p><i>“which church do you go to?” So there’s an assumption that everybody belongs to a church community. So I don’t per se feel dissonance rather recognize where it comes from, that it is important in society.</i></p> <p>2. <i>For many people, yes it is part of their culture. They might be very involved in the church. They often find that their support system resides in the church. I’ve seen some patients and sometimes on reflection, I would have thought unlikely patients, find tremendous support in church community.</i></p> <p>3. <i>In African black community where I was, and you know twenty-five years ago or whatever it is now, it was impossible to leave that (religion and spirituality) out. In fact, it was one of the very early questions - who has helped you, have you been to a traditional healer, have you been to a Sangoma, what did they say? Brining that conversation on board, because otherwise you are hitting your head against a brick wall so I think I have allowed myself to see that (religion and spirituality) as a potential partner in working with people from a psychological perspective.</i></p>	<p>framework with which people construct meaning in their lives.</p> <p>The dissonance that is referred to is the fact that the psychologist does not feel a sense of dissonance when considering religion, spirituality and psychology alongside one another.</p> <ul style="list-style-type: none"> <li>- Repeated Theme:</li> <li>- Religion plays a fundamental role in clients’ worldviews and the manner in which they interact, therefore, with daily living.</li> </ul> <p>Note: Psychologist I was the only psychologist who specifically mentioned the function of belonging that is associated with religion and spirituality, and how this connects a client to a specific community. The latent and manifest meaning</p>
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		in Psych. I's second statement demonstrates that R/S cannot be separated from the concept of culture.
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From the table above, it is clear that there is a commonality amongst the responses that the psychologists gave. I indicated repeated themes interpreted from the data in order to show that there is agreement in how the psychologists saw the interface between religion, spirituality and psychology (mental health). For the purpose of reviewing this agreement and commonality, the most common themes that were drawn from the data regarding this topic in order of frequency were:

1. The interface of religion, spirituality and psychology is inseparable and overlapping;
2. Religion and spirituality form a framework with which people construct meaning in their lives;
3. It is not possible to consider psychological functioning without an analysis of the R/S factors that may be influencing this functioning;
4. Religion plays a fundamental role in clients' worldviews and the manner in which they interact, therefore, with daily living; and
5. Religious and spiritual beliefs seem to hold significance for the vast majority of South Africans.

This unifying opinion demonstrates that each of the psychologists appreciates the extent to which religion and spirituality can interface with psychology. There was no denial of the fact that these three constructs must be considered alongside one another. There were two psychologists (H and I) who spoke about the specific context of South Africa in how they understand the interface of religion, spirituality and psychology (mental health). However, when reading all the transcripts and analysing the narratives of the transcripts, it was found that each of the psychologists interviewed spoke about the place of religion and spirituality in an idiosyncratically South African population. It is imperative, therefore, to recognise that the above tabulated responses were made within the context of South Africa's socio-political

milieu, and therefore particular to South African dynamics. This will be discussed in Theme Four when we consider stigmatisation.

Having established the fact that the psychologists think that religion, spirituality and psychology (mental health) are inextricably interfaced, a few follow-up questions arise. Although the psychologists stated their perception about the salient role of religion and spirituality for a client or patient, I was still left wondering what their perceptions were about the actual integration of religion, spirituality and psychology. An opinion that religion and spirituality is of importance for clients does not necessarily mean that the psychologists perceive the actual integration of religion, spirituality and psychology to be an imperative one. To make that assumption would be faulty logic. Therefore, the next most obvious question is what their perceptions of the necessity for integration are, and the question of how this integration should then take place. It is with these questions that the third theme can be introduced where the perceptions and the “how to” of the integration of religion, spirituality and psychology are explored.

### **Theme Three: The Integration of Religion, Spirituality and Psychology**

The psychologists provided information about the numerous perceptions they have about the integration of the realms of religion and spirituality when treating clients or patients, and within those responses they also gave an indication of how the integration should take place. In order to gain insight into this, the perceptions of the psychologists will be discussed, which will then be followed by a review of how they integrate those realms.

As mentioned in Theme One, there are many factors that have contributed to the development of the psychologists’ perceptions of religion and spirituality. The majority of those factors intersect with how they perceive the need for or approach to the integration of the three realms. This was visible in the fact that the psychologists’ perceptions of integration were primarily influenced by their own personal positions of faith. In general, the psychologists who placed personal value on religious and spiritual beliefs were the psychologists who were the most comfortable with the integration of religion and spirituality when treating clients/patients. It was also these psychologists who more regularly advocated for an inclusion of such integration in the curricula of their academic institutions. Personal faith as an influencing factor

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of the value of integration was closely followed by a few other factors as shown in the table below:

*Table 26*

*Factors that Influence Psychologists' Perceptions of Religion, Spirituality, and Psychology*

<b>Factors that Influence the Psychologists' Perceptions of Religion, Spirituality and Psychology</b>
1. Personal religious and spiritual beliefs
2. Formative training on the integration of religion and spirituality during undergraduate and graduate training
3. The perspectives of and approach to integration that is followed in the departments or faculties in which the psychologists work

The influence of undergraduate, graduate and departmental attitudes towards integration will be more fully discussed in Theme Four.

With all the above dynamics taken into consideration, the overarching and narrative interpretation of the interview transcripts in their entirety still showed that psychologists perceive the integration of religion, spirituality and psychology to be necessary and valid within a South African context. This was reiterated by the psychologists in reference to South Africa being described as a conservative country where religion and spirituality remain an integral part of this nation's culture. If we are to place substantial gravity on a comprehensive analysis of one's culture and the impact thereof, then religious and spiritual aspects must be awarded recognition within that analysis.

In order to capture the overall gravitas of how these perceptions of integration operate for the psychologists, I would like to borrow from Charmaz's (2008) grounded theory methodology by making use of an "in vivo" code, as this will aptly illustrate the complexity of the psychologists' perceptions about integration. One of the psychologists interviewed referred to the fact that placing the terms religion, spirituality and psychology alongside one another can often bring a level of discomfort and tension. She pondered this tension for some time, and then said the following:

*Response: I think there's a - there is a conflict it's –  
It's an unnamed conflict.*

The use of the phrase “unnamed conflict” was striking, because many of the psychologists struggled to clearly articulate the nature of the resistance experienced when it comes to integrating the three domains of religion, spirituality and psychology. A few of them offered theories as to why the tension exists, which was usually connected to stigmatisation, and will be reviewed in Theme Four. Sometimes, the “unnamed conflict” was mentioned in specific reference to the religion of Christianity, as if there is a greater sense of uneasiness about the integration of Christianity than there is about other religions:

(Same psychologist as above using Responses 2 - 4 in expanding on her definition of “unnamed conflict”)

*Response 2: The conflict is when - let me put it this way, when some aspects of Psychology are seen, or there at least spiritually, seen as benign and others or other spiritually positions are seen as ..... as difficult ..... so for example people tend to have a very strong response or reaction to someone who is a Christian...*

*Response 3: I know when we were doing selections like “oh, she's a Christian, she's -she's rigid” and I'm like, how do you know that? Because we haven't met the person and and things like that. Where it's for example (other religions)..... we don't ask the same.... we don't exact the same standard for example around other religions or spiritual actions and so on. And so the tensions come again when, when you look at what we seek to do, or what we think we're doing, so when you're trying to understand somebody's difficulties and we come with things like it's a problem of self-esteem, it's a problem of this and so on and it sounds benign but it's not benign.....*

(she goes on to explain that Psychology may see self-esteem as a benign construct but actually for some Christians it interferes with the religious and spiritual belief that one should operate out of a position of humility verses self-actualisation and self-improvement)

*Response 4: And then I see the tension with students who come in who are Christians...I have to train them and I will train them in this uh 'inner paradigm' and I see the struggle that they have, and sometimes where they almost feel like they need to give up their spiritual beliefs and and things like that.....*

The psychologist mentions a few aspects of the unnamed conflict in Responses 2 – 4. She reiterates that it seems to be more prevalent when there is the mention of Christianity. This is illustrated in Response 3 through the example of selection processes where she has witnessed candidates being disregarded in paper selection rounds due to their professed Christianity. As mentioned previously, there is an assumption that Christianity and rigidity are closely linked, which I will discuss again in Theme Four. In Response 2, this psychologist considers the fact that some concepts in Psychology for example, self-esteem are considered to be spiritually benign, however within the world of Christian religion, the way that Psychology defines self-esteem may not be as benign as purported. Lastly, Response 4 describes the inner turmoil of Christian students that she has witnessed when training at a Master's level. The students seem to think that they are required to give up their Christian faith in order to be "effective" psychologists, which she disagrees with.

Of central importance though, is this psychologist's opinion that "*we don't exact the same standard, for example, around other religions or spiritual actions and so on and so the tension...*". Therefore, she is stating that the integration of religion and spirituality is viewed differently when it is the Christian religion that is being considered versus other religions. This feeds into the notion of an unnamed conflict, because, for her, there is a dearth of explanation and reasoning as to why the tension is more palpable when it comes to Christianity. The stigmatisation around Christianity will be discussed further in Theme Four. However, it is interesting to note that of the nine psychologists who were interviewed, seven of them voiced agreement that there is resistance to the integration of Christian beliefs within Psychology to a greater extent than other religions. Another psychologist echoed this opinion with the following statement:

*Response: I think for me in terms of training psychologists, for me, you know, if I can fall back on a kind of very psychoanalytic idea, empty.... Chris-folderol..... and if I consider how this person would function..... then I have to consider what his or her spiritual beliefs are.*

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This comment was made in reference to the fact that generally, South African Psychology departments do not place emphasis on religion and spirituality in the training of psychologists, because there is still a sense that religion, spirituality and God are “folderol” (the term folderol is defined by the Oxford dictionary as meaning a useless ornament or accessory, trifle, or nonsense). Therefore, this psychologist was implying that the discipline of Psychology perceives training in religious or spiritual integration to be frivolous.

Although religion, spirituality and God may be perceived by some as “folderol”, the concept of cultural sensitivity, respect and acceptance as one that is dominant in this country, and is afforded much magnitude. When considering the integration of religion, spirituality and psychology, the majority of the psychologists linked it to an integration of culture. The implication was that religion and spirituality form a part of someone’s culture and must therefore be respected accordingly. That being said, many of the psychologists further expanded on this discussion of culture by stating that the integration of religion, spirituality and psychology is a particularly complex one for the context of South Africa. This is a diverse nation of cultural identities and languages, and this is a country that carries the scars of our political past, with some of that scarring associated with religion and spirituality. Integration, therefore, has to be duly considered in the light of these complex socio-political and historical dynamics.

The following excerpts from the interviews illustrate some of these points:

*Response 1: In South Africa we have a large part of our population who does believe in things like bewitchment and curses and trans-generational issues from forefathers and those are real spiritual beliefs and experiences and can't be dismissed as psycho-pathological or dysfunctional but should be taken into account.*

*Response 2: I don't know – it (integration in South Africa) just it feels complex - this country is complex.....Here it's just complicated and the past has made it even worse...*

*Response 3: It's two fold, I think its both of what you have mentioned, you know, there is a nervousness(in South Africa) I think, we don't know enough about it, but I also think ... that's the one side for me. And I think the other side is simply that we have a prime directive, you know, just keep the status quo and that's where we at, and so we can talk about these other issues, but we always come back to the default which is the status quo. And, yes, and that's quite archaic.*

*Response 4: I think it's a matter of competence. In South Africa people feel they don't have the competence (to integrate)*

*Response 5: Well I kind of blame our context (for not integrating spirituality and religion sufficiently), our South African context, and specifically political history in a sense where, huh, we are very specific uh uh religious groupings and uh they quite set in their ways*

*Response 6: Eighty percent of blacks uh are Christian anyway even if they practice a dualistic African belief so ya it plays a very important role. Very often even if patient is admitted into a psychiatric ward we'll give them a pass over the weekend to do a ritual uh, because they believe that what we are diagnosing is schizophrenia and maybe actually that they have not appeased an ancestor so we actually send them over the weekend to go and do that in spite of... so that kind of merging of treatments become important if you want to attend to the psychological and psychiatric needs that individuals have.*

*Response 7: I do see clients who are very religious but who have a kind of nuance in which way they integrate themselves. Their belief systems with their faith with their political belief systems and the way in that they see themselves in the world.*

*Response 8: In this society in South Africa, it is something that is very important to people. It does come up fairly often. In fact, people use it as part of their identity. They tell you who they are and what they do and what their religion is. What church they go to. So I think we probably should find a way of bringing it into the conversation when we train students*

These responses demonstrate that religion and spirituality can be integrated into a person's cultural identity but that there are complexities in the South African context that can make the integration of religion, spirituality and psychology a more contentious discussion. Be this as it may, there is a recognition by the psychologists that religion and spirituality play a central role for many South Africans and that it should, therefore, be recognised. Responses 1 – 5 carry either a manifest or latent implication that there is some resistance when it comes to integration. This question was not originally included in the interview protocol, but was one of the discussions that I initiated with the psychologists when I was able to perceive that they were referring to a sense of this resistance.

There were a few reasons given as to why there might be resistance to the integration of religion, spirituality, and psychology. One of those reasons, as discussed, was the complexity of South African society and culture, and how religion/spirituality may be linked to South Africa's political past. Added to this reasoning was the opinion voiced by a few psychologists who thought that the resistance to integration came from Psychology's fear of appearing "unscientific":

*Response 1: I know there's such a strong continued push to separate faith and science in a sense.... I also think that a particular challenge is that Psychology is very anxious within itself as a discipline and we spoke a little bit earlier about that, but I think that is a big, big part of it. So I think what happens then is that Psychology or practitioners of Psychology who do value spirituality and the church simply go underground.*

*Response 2: Psychology has been so desperate to be a science you know so we are at pains all the time to set ourselves up as scientists and we want to be accepted by ultimately by physicists, because that's the ultimate science so Psychology has been so at pains to prove that we're a science and you know we don't religion seems so wishy-washy and it's going to undermine our credibility as scientists*

As can be seen from the responses above, the assumption that the integration of religion and spirituality within the South African context is a simple one, is faulty. Rather, there

are a myriad of factors that should be taken into account when approaching the discussion of integration. To gain information on this, the psychologists were asked about their approaches to integrating religion and spirituality in their clinical practices.

**Category 3.1: Psychologists’ Approaches Followed in Integrating Religion, Spirituality, and Psychology**

There were two main ways that the psychologists described these approaches and these were therefore coded into two classifications. The first classification was coded as “stance” and the second was coded as “practice”. This is because some of the mechanisms of integration described by the psychologists do not depict an overt action per se, but rather an overall attitude or stance that the psychologists embed themselves in when approaching integration. The latter has been named “practice”, because these were examples given of overt actions or protocols that the psychologists follow in order to allow for integration to take place. When this stance or practice has been repeated, it has been indicated as such in the table so that the frequency of those stances and practices is visible. The results will be depicted in a table similar to the one above so that repetitions can be captured and discussed:

*Table 27  
Psychologists’ Approaches to the Integration of Religion, Spirituality, and Psychology*

<b>Psychologist</b>	<b>Response Given</b>	<b>Context or Meaning</b>
Psych. A	<p>1. <i>I listen to peoples’ religious beliefs and feelings and associations but I don’t necessarily intervene in that context so it’s more of a history taking context or view or stance I take and that is basically how I interact with religion or spirituality</i></p> <p>2. <i>When you express yourself as a therapist about their religious</i></p>	<ul style="list-style-type: none"> <li>- Religion and spirituality is asked in the history taking phase.</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients give.</li> </ul>

	<p><i>beliefs and tell a patient that you think they are too rigid in what they believe - obviously you won't do it in that kind of direct way - then you also kind of walk the risk of pushing the patient away or making them feel that you don't understand why they believe in it... but that again brings me back to the approach - if you have a more existentialist phenomenological approach then you will never tell them it's too rigid. You will help them ascertain whether this belief is working for them in their lives in making them grow and feel healthy spiritually as a person.</i></p> <p>3. <i>I actually believe confrontation in psychotherapy is something that doesn't belong in psychotherapy. We are not there to confront patients - not what they believe, we are there to offer them</i></p>	<ul style="list-style-type: none"> <li>- Confrontation is not a helpful way to deal with religious and spiritual beliefs and may cause the patient to distance themselves from the process.</li> <li>- An existential/phenomenological approach is used so that the meaning of the clients' beliefs can be understood.</li> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li> <li>- Religious and spiritual beliefs should be beneficial to psychological growth.</li> <li>- The introduction of religious and spiritual content is purely client-led and is not directed by the psychologist's agenda.</li> </ul>
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	<p><i>alternative ways of thinking and believing and viewing themselves but in a non-confrontational way, because the world out there confronts everybody already.</i></p> <p><i>4. I never kind of introduce specific religious thoughts or beliefs but I do explore spirituality with patients as I believe it is part and parcel of who we are as human beings.</i></p>	
<p>Psych. B</p>	<p><i>1. I have in my intake, the intake interview there will just be very basic question on paper, the form they fill in, that is do you go to church, if yes, has there been a change in your spiritual life lately? How many times, how regularly do you go to church, just very basic that will give me an idea where the person is at and not necessarily in the first interview will I inquire, but most probably later on I will</i></p>	<ul style="list-style-type: none"> <li>- Repeated Practice:</li> <li>- Religion and spirituality is asked in the history taking phase.</li> </ul>

	<p><i>explore the spiritual a little bit more.</i></p> <p>2. <i>I will work with whatever the client is presenting. I will only bring in a spiritual intervention if it's really part of what the client needs or when it's part of the context that I think it makes sense, it has meaning or yes I think we should also speak about this or the client speaks about it.</i></p>	<ul style="list-style-type: none"> <li>- The psychologist generally allows the introduction of religious and spiritual content to be client-led, but will at times integrate such content if they deem it to be in the clients' best interests.</li> </ul>
<p>Psych. C</p>	<p>1. <i>All you have to do is listen to this person and ask about them about the importance of this in their lives, just an openness as well, just to say ok tell me about that, it sounds like that's an important part of you.</i></p> <p>2. <i>You have to ask, who are they, where do they come from, what does this mean for how you understand this thing and wh-what does it mean for your intervention. So if you got to come up with a treatment plan you need to think about whether it</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients give.</li> <li>- The religious and spiritual beliefs that a client discloses must be incorporated in how the psychologist proceeds with the assessment and treatment phases.</li> </ul>

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	<p><i>actually works, whether it-it fits, whether actually it would work with this person or it's contrary to everything that they do and everything they believe.</i></p>	
<p>Psych. D</p>	<ol style="list-style-type: none"> <li>1. <i>What it means is I can join this person, and then I can ask, I can have an enquiring stance and find what it is they believe, and how they practice and how that serves them in their life, so then I will be able to pick up the pattern.</i></li> <li>2. <i>I have to ask, I can't possibly know every belief system. I need to be open, I need to be able to remain curious, I need to be able to explore, that's a basic skill.</i></li> <li>3. <i>I'd prefer to use the analogy that I think about religious beliefs the same way I think about defences. So, defences are useful and they serve a function. If they are rigid, fixated, inappropriate to the</i></li> </ol>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients give.</li>   <li>- The valence underlying the client's religious and spiritual beliefs should be assessed clinically by the psychologist and the client's level of insight into this valence must be determined.</li> </ul>

	<p><i>situation, they are not useful. But if they assist adaptive coping, be it in a traumatic situation or in a normal adjusting period, then they are functional. You know, and for me, if that's what I'm sitting with then it's always about the level of insight that someone has into the way they use their defences.</i></p> <p>4. <i>How is someone practicing their faith? Does it become something that enhances his resilience, does it become something that provides them support and an anchor, or is this a flight into a belief system that's not useful, that hasn't served him well, but it's not the belief itself, it is the practice and I think that's get lost a little bit.</i></p> <p>5. <i>I mean in my intake, I mean if someone is Christian for example then I'll say, so describe to me how you experience</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- Religious and spiritual beliefs should be beneficial to psychological growth.</li> </ul> <ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- Religion and spirituality is asked in the history taking phase.</li> </ul>
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	<p><i>God, how is it like for you, how do you see Allah or whatever and I ask this because it is such an important part in how they relate, how they parent, and how they decision-make.</i></p> <p>6. <i>The diagnostic inquiry sits alongside the spiritual enquiry. So what is your doctrine of the particular church that you're attending, what role is that playing in your life, what is your faith in these systems.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li> </ul> <p>Note: The phrase “the diagnostic inquiry sits alongside the spiritual enquiry” captured the essence of what many of the psychologists were expressing.</p> <ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- The religious and spiritual beliefs that a client discloses must be incorporated in how the psychologist proceeds with the assessment and treatment phases.</li> </ul>
Psych. E	<p>1. <i>I've been very receptive to joining people on kind of a spiritual journey and a lot of the time for me,</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- The interface of religion, spirituality and psychology is inseparable and overlapping.</li> </ul>

	<p><i>all the time it seems the interface between the two is so close, half the time they're talking to me about spiritual issues.</i></p> <p>2. <i>This is the best work to be with people who are religiously open-minded and want to deal with psychological issues. It's incredibly rich and so that's what I like doing most I mean I see people with a whole range of conditions but that for me is the most stimulating part of my work.</i></p> <p>3. <i>I have respect, I don't have the right to violate anybody else's belief system. I would try and understand it, I will try and look all the time for possibilities of opening it.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients give.</li>   <li>- Repeated Practice</li> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li> </ul>
<p>Psych. F</p>	<p>1. <i>I wait for it to come to me from the patient, where do they sit with these concepts, constructs or things, what they mean to them.</i></p> <p>2. <i>It's per... it's pervasive, and powerful so I don't</i></p>	<ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- The introduction of religious and spiritual content is purely client-led and is not directed by the psychologist's agenda.</li>   <li>- Repeated Stance</li> <li>- Confrontation is not a helpful way to deal with religious and</li> </ul>

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	<p><i>feel to attack or confront or.... you know....</i></p> <p>3. <i>I've got big respect for religiosity and religions and that, but I can still sit there and say "what about this", "let me throw this at you", throw that at you uh "let's look at it from a different angle". What if this, what if that, did you think about that? So it just opens it up a bit more and then to say but can we wait a bit? Just hang back until we've really, you know, revisited and looked and spoken. think the final answer must come for that person through that uh it must be a workable answer for them in their religiosity.</i></p> <p>4. <i>It's for me as a therapist to see how it is fixed in view of the patient, how it can be a positive or a negative thing.</i></p>	<p>spiritual beliefs and may cause the patient to distance themselves from the process.</p> <ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li> </ul> <ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- Religious and spiritual beliefs should be beneficial to psychological growth.</li> </ul>
Psych. G	1. <i>There's no way I would know enough about their</i>	- Repeated Practice

	<p><i>own sense of faith and their connection with their religion or their belief with God, so it's really about saying given this, it's either that or this, what is it that you can do now if this is a test for you. If someone who is saying I'm tested this is a test and God was testing my faith then I would ask them to think a little about if that's the faith, there is always a sense of God as being very benign and merciful and God also being very punitive. So what is your experience of this, maybe how you are thinking about it. So what is that you think that God would want you to feel inside yourself to manage the difficulties you're experiencing now.</i></p> <p>2. <i>I could just to make sense of it, that if this is important for you to believe this or the other but what is it that you</i></p>	<ul style="list-style-type: none"> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li>   <li>- Repeated Stance</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as</li> </ul>
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	<p><i>would need to do for yourself.</i></p> <p>3. <i>In the spiritual sense it's about having to find meaning where you are at and how you are at peace with the world and yourself that doesn't leave you stuck between are you going against your church, are you going against the mosque, are you going against the temple, while trying to navigate a sense of being in the world.</i></p>	<p>well as listen to the answers the clients give.</p> <ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- Religious and spiritual beliefs should be beneficial to psychological growth.</li> </ul> <p>Note: In this specific response, Psych. G stated that psychological growth would include the persons feeling at peace with themselves and not feeling as if they had acted in opposition to their faith-based institution. This is an important addition to the themed stance of psychological growth.</p>
<p>Psych. H</p>	<p>1. <i>Religious and spiritual, those beliefs are going to impact on their existential being so when those beliefs come through in psychotherapy we need to be able to know what to do with them as clinicians too and how to help the patients make sense of them, how to recognize what is helpful and what</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- An existential approach is used so that the meaning of the clients' beliefs can be understood.</li> <li>- Repeated Practice</li> <li>- The religious and spiritual beliefs that a client discloses must be incorporated in how</li> </ul>

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	<p><i>is unhelpful too, when it comes to religion and spirituality, 'cause there is a continuum.</i></p>	<p>the psychologist proceeds with the assessment and treatment phases.</p> <ul style="list-style-type: none"> <li>- The valence of the religious and spiritual belief is something that the psychologist needs to assist the client in recognising.</li> </ul>
<p>Psych. I</p>	<p><i>1. The most profoundly religious people have doubts. I don't believe that it's possible to adhere to religion rigidly throughout one's life without ever a doubt crossing one's mind. In fact, you read the lives of the great saints and the great philosophers, religious philosophers, they've all gone through a period of great doubt. So that forms part of religion. So I think that most people are open to reflecting on what they believe and how it impacts on their lives without rejecting the preaching of their church and I think that's really what we need to tap into.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Practice</li> <li>- A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.</li> <li>- Repeated Stance</li> <li>- A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients.</li> </ul>

	<p>2. <i>I'm not going to jump in there and confront their religious belief. That's their right to have that. But rather to kind of work with it in some way and get them to help me understand where they are coming from with that and then engage in conversation. Not to question their faith but to question possibilities around that.</i></p> <p>3. <i>Even with someone who was clearly rigid and had very strong beliefs about this (religion and spirituality) I found that I could talk to him about alternative ways of looking at it. Alternative ways of thinking about it without bringing his religion into it.</i></p> <p>4. <i>In some form or another, ask them why it is important to them. What do they think? Get them to tell me about the role of religion in their lives.</i></p>	<ul style="list-style-type: none"> <li>- Repeated Stance</li> <li>- Confrontation is not a helpful way to deal with religious and spiritual beliefs and may cause the patient to distance themselves from the process. It is not the psychologist's right to confront that belief.</li> </ul>
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## THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH

The psychologists' responses show how there was a differentiation between therapeutic stance versus psychological practice when it comes to the integration of religion and spirituality within a psychological process. To review these stances and practices, they will be provided below in order of the most to the least frequently mentioned:

### Stances:

1. A psychologist must have an attitude of openness where they can ask questions about religion and spirituality, as well as listen to the answers the clients give.
2. Religious and spiritual beliefs should be beneficial to psychological growth.
3. Confrontation is not a helpful way to deal with religious and spiritual beliefs and may cause the patient to distance themselves from the process. It is not the psychologist's right to confront that belief.

### Practices:

1. A clinician can assist a client in creating a platform within which religious and spiritual beliefs can be discussed and reviewed.
2. Religion and spirituality is asked in the history taking phase.
3. The religious and spiritual beliefs that a client discloses must be incorporated in how the psychologist proceeds with the assessment and treatment phase.
4. The introduction of religious and spiritual content is purely client-led and is not directed by the psychologist's agenda.

(Equal frequency 5 – 8)

5. An existential approach is used so that the meaning of the clients' beliefs can be understood.
6. The psychologist generally allows the introduction of religious and spiritual content to be client-led, but will at times integrate such content if they deem it to be in the clients' best interests.
7. The valence underlying the client's religious and spiritual beliefs should be assessed clinically by the psychologist and the client's level of insight into this valence must be determined.

8. The valence of the religious and spiritual belief is something that the psychologist needs to assist the client in recognising.

These stances and practices were drawn from the data provided, but are by no means exhaustive when considering effective integration. For example, the consideration of transference and countertransference is a salient one when working with religious and spiritual content, but only two of the interviewed psychologists made explicit reference to this. Further suggestions for the effective integration of religion and spirituality will be discussed in greater detail in Chapter Six. Many of the principles discussed in this section will be paralleled to other sources of research so that a model applicable to the South African context can be proposed in relation to the pertinent issues raised in this section.

### **Category 3.2. The Ethics of Integration**

A discussion about integration is impossible without a thorough examination into an accompanying ethical framework. Each psychologist spoke about ethical practice, scopes of practice, and the statutory requirements of the Health Professions Council of South Africa. Most consistently, the psychologists reiterated the necessity for integration of religious and spiritual beliefs to be interwoven with ethical requirements and standards of professional practice. Some of the psychologists openly expressed fear and apprehension in connection with integration based on the perceived lack of statutory guidelines and regulations for the intricacies of ethical integration. On the other hand, there were some psychologists who felt that the ethical transgression lay in ignoring a client's religious and spiritual beliefs, as opposed to the ethical practice of integrating these beliefs. Two of the psychologists said that they advertise themselves as Christian psychologists, because they believe that it is their constitutional right to affiliate with a particular religion, and to be transparent in that affiliation so that their clients can make informed decisions about whether or not to consult with them.

Similarly, there were divergent views when it came to the nature of the integration that should take place. Siang Yang-Tan (2011) classifies two main forms of integration, namely implicit integration and explicit integration. Implicit integration is defined as an attitude or stance that the psychotherapist incorporates that shows respect for religious beliefs and discussion around those beliefs, but there is no overt use of prayer or spiritual intervention in the process of psychotherapy. This is contrasted to explicit integration which does involve overt

spiritual actions and intervention, for example, prayer, reading of Scripture, and religiously based homework. One of the more contentious points of this debate is the place of prayer in a psychotherapeutic process. For the purposes of this section, however, excerpts to show how contentious the debate between implicit and explicit integration can become follows:

*Response 1: Because it's ironic that people can say that students must meditate and do this at student wellness but you can't say to your student what do you want to pray....*

*Response 2: What a lot of psychologists are very worried about.....I always see that their fantasy is that if a psychologist or health professional says, we can work with spirituality, then their idea, their fantasy is that you are praying here in the room with a client. And, you know, that isn't what it means. What it means is I can join this person, and then I can ask, I can have an enquiring stance and find what it is they believe. And how they practice and how that serves them in their life, so then I will be able to pick up the pattern, you know. And I think that's the fundamental difference when it becomes to spirituality knowing about that and being able to work with it, is not the same as believing in it. And I think there is a way in which people think if I acknowledge that I work with spirituality and it is a given as a factor, as an etiological consideration, as prognostic indicator, then I am believing in it. I don't think they are the same things.*

*Response 3: I think a psychologist working at a Christian church for instance, I think should be in a position to be able to pray with their client, like a Muslim psychologist working at a mosque for instance should be able to give more exact spiritual guidelines and practices from that particular perspective. But I do think one should always ask yourself - what is the role of the psychologist? because we are psychologists we remain - our primary focus remains the psychological functioning of the human being of which that spiritual and religious function is a part, but we are not primarily there to give religious advice or to do the religious practices with our clients. Because then also you can imagine in terms of the medical aids' reimbursement of treatment - that is not what we are doing, we need to treat psychological conditions if that then involves spiritual counseling and spiritual dimensions, yes, I think we should go*

*there but I don't.....I have never prayed with a client in my 16 years of practice. Not that that is a good or a bad thing, maybe I should have in some cases but the point is that I always ask myself what is my role here? I will encourage prayer for instance between a couple, a Christian couple, or even I even encouraged the Hindu lady I'm seeing the other day to also open herself up more spiritually and finding her faith again in whatever that is and the specifics of it. So I can give religious advice and guidance in the broad sense but I don't believe we should fall into specific practices. That is again the boundary issue, the same thing as hugging, prayer is a very intimate thing*

*Response 4: so I think again if you know the research and you know how to use prayer in a responsible and ethical way it is very therapeutic. It's for me then it is part of our discipline. If a client is open for that, if a client wants that. So prayer I don't have a problem with prayer at all, because I think it is a therapeutic method that we can use in a therapeutic way. Something like meditative prayer or contemplative prayer or just to acknowledge God's presence of God's authority if a client so wishes. I don't think prayer should then become the main method of working. You know that's all that you have in your process. It can certainly be part of a process but the same with looking at Scripture or interpreting Scripture there's there can Scripture has a lot of value in terms of psychological wisdom. And if it's done as part of process, to add to your process I think for me there's no problem with that. If Scripture is used to condemn or to identify sin or it can become it shouldn't be a method to sort of force your client to gain insight you know it should be something that the client can just learn from in a very natural way as part of the therapeutic process.*

*Response 5: I think when you cross boundaries you know uh the... what is the role of prayer? It's it's different to psychotherapy you understand? Then what stops you having a Bible study together? You know so ya so I think it's very important to keep the boundaries, because you're gonna get uh ... kind of into a place where you don't know what's your role. And remember psychologists you're registered with a body the purpose of the regulated body is to protect the public and to guide the profession. So that's why regulation takes place, so you're ensuring that the person who is treating you is competent enough to do*

*that and you protecting that person. Now the point is when uh when you start to edge into areas you are not trained into you are on a very slippery slope.*

These responses once again indicate that there is much diversity in how ethical practice is interpreted and implemented by the psychologists in relation to integration. This may be because there is no ethical framework provided for psychologists that specifically reviews the integration of religion and spirituality in psychological practice. Even in the absence of such a framework, there were five main ethical principles that the psychologists mentioned throughout their interviews in reference to integration, and their agreement on these 5 principles was unanimous:

1. The client/patient has the right to hold religious and spiritual beliefs that differ from the psychologist's beliefs without being judged for these beliefs;
2. A psychologist may not impose their own beliefs or views onto the client/patient;

(Both principle 1 and 2 make reference to the constitutional right to freedom of religious belief and expression without prejudice.)

3. The context of psychotherapy is not one in which proselytisation is permitted;
4. Professional boundaries must be maintained at all times; and
5. The scope of practice of a psychologist should be the primary directive guiding a psychologist's decision-making.

As shown in the previous discussion, the ethical principle regarding the use of prayer and other religious or spiritually based interventions was a principle that lacked cohesive agreement. This is most likely because there is no specified guideline that directs psychological practice in South Africa in terms of implicit or explicit integration, and so it becomes something that the psychologists assume should be determined "at the psychologist's own discretion".

In the event, however, that integration does take place, the psychologists stated that it would have to be ethical in nature. The ethical implications for integration were at the forefront of the psychologists' concerns throughout the interviews. For ethical integration to be possible, the psychologists agreed that the following issues should be addressed urgently within the discipline of Psychology:

1. Defining ethical guidelines for the integrating of clients/patients' religious and spiritual beliefs within the practice of Psychology;
2. Defining scopes of practice for Psychology which review available evidence-based interventions for working with religion and spirituality; and
3. Defining the psychotherapeutic context in which integration takes place.
  - This would include an emphasis on client-led principles.

### **Category 3.3: Moving Forward with Integration**

Similarly to the interviews with the pastors, the last question posed to the psychologists was how they foresaw the process of integration moving forward. This process included how psychologists thought they should interact with the church and pastors as a means of moving forward. The reason that this question was posed to the psychologists is because they were undivided in their perception that religious and spiritual beliefs ought to be integrated into psychological processes within a South African context. The logical question that flowed from this perception was the “how to” of moving forward. The psychologists' responses fell into two main realms, the first being how integration should occur within the profession of Psychology itself (intradisciplinary), and the second being how integration can be fostered through interdisciplinary collaboration.

#### **Subcategory 3.3.1. Intradisciplinary integration**

When looking at intradisciplinary integration, all of the psychologists were unanimous in naming four ways in which this should occur:

1. The establishment of an ethical framework for working with religious and spiritual beliefs;
2. Training and education;
3. Openness and communication; and
4. The redress of stigmatisation and prejudice.

Item number one is self-explanatory due to the discussion in the introduction section of Theme Three. The necessity for psychologists to know how to work with religious and spiritual beliefs in an ethical manner is absolutely mandatory if there is to be efficacious integration. However, linked to this, is the vacuum of training and education within

undergraduate and graduate degrees emphasised by each psychologist. The only interviewed psychologist who had received any formal training on religious and spiritual beliefs within the context of psychological practice was the psychologist who had completed some of his/her graduate training in the United States of America.

The training and education for integration, which the South African Universities represented in the study had included in their curricula, was equally sparse. Of the six universities represented in this study, only one of the institutions includes some detailed training on religion and spirituality, which was in the context of the biopsychosocial-spiritual model (BPSS model). The psychologists said that the majority of the time, religion and spirituality is placed under the umbrella of “culture”, and is merely made reference to as being one of the possible components of a client’s culture. A few comments illustrate this:

*Response 1: We include it (in BPSS model) but we kind of pay lip service to it.....*

*Response 2: Interviewer: where do you think we are as a field in terms of the element of religion and spirituality?*

*Response 2: Mmm, yo almost nowhere I think. I think we have done with it I suppose what many fields do with it and we've put it there to one side and we said no but we are “clinicians and uh professionals” ....(intonating that it is not our realm of inquiry, because we should be scientifically minded).*

*Response 3: It is one of many discourses that we don't touch on. And it is quite polarised....*

*Response 4: Broadly speaking there are issues such as this (religion and spirituality in culture) that we don't touch in the work. For example, we don't spend enough time on family therapy systems.....which is good place to bring religion and spirituality in.*

*Response 5: I think we think about “what is the context”...Social, cultural context, per se, but in terms of the culture itself we-we just kind of leave that (religion and spirituality) out.*

The psychologists thought that the lack of training in relation to matters of religion and spirituality is due to a lack of funding in South Africa to incentivize and encourage the relevant research:

*Response 1: I suppose our history has made that we have chosen the focus on trauma and healing and dealing with issues that are in society especially with inequality and the desperate nature of the work and we all work, and I imagine you do as we do, with violence-related rehabilitation so if we're doing that it's almost like this (religion and spirituality) is a nice-to-have but it can't wait, the funding can wait for this, because we still need to look at what kind of therapy works for the low-income communities. I think that's where the national priorities place funding and resources, because they require now to have an understanding of continuous traumatic stress but they don't require a need for looking at religiosity and its impact.*

*Response 2: You are going to have a harder time getting funding for your project on spirituality, you know. So, I think we haven't had people in the academia with a strong enough interest in it and then I also think that our funding and our structures are biased too, you know what's kind of the issue of the day, whereas I think in other countries there's so much more funding for example and there's a greater level of tolerance for alternate foci.....so we don't get to it curriculumise it, don't really talk about it, we can talk about gender and identity and we can talk about intersectionality and we can talk about decolonisation, but I think in a way we can't talk about spirituality really. So there are not drivers and I don't think the system allows it either.*

*Response 3: I think there is always like in the bigger scheme of things in terms of social, political environments in which research funding is given type of contexts in which people stay away from issues that might cause any conflict. So for instance in the Psychology department has 10% Hindu affiliated lecturers and 30% Christian affiliated lecturers and 20% Muslim affiliated lecturers and they might say but you know to do research in a specific religion would be biased or might be discriminating, so then they'd rather stay away from issues like that.*

Whether or not funding was specifically stated as being a reason for the lack of education and training depended on the trajectory in which the interview proceeded. However, every psychologist interviewed made a deliberate statement pertaining to the opinion that the training and education of psychologists in South Africa is sorely lacking in a myriad of ways, not just with religion and spirituality, but with other subjects for example, the inclusion of content relevant to LGBTQI themes. Every psychologist further stipulated that the religious and spiritual aspect to client/patient assessment or treatment is an imperative component of training. These are subject areas that the psychologists said cannot be neglected without there being serious consequences to the integrity of the profession of Psychology.

With the concerns about education and training being mentioned, the psychologists expressed hope that the decolonisation movement that has swept through South Africa recently would bring a shift in how curricula are structured for future Psychology degrees. Many of the psychologists spoke about their experiences of black South Africans being intrinsically spiritual and religious in the array of African, cultural, traditional and religious beliefs represented across ethnicities. That, coupled with the decolonisation of curricula, was predicted to be an opportunity for black South Africans to raise their objections to Westernised subject matter that they find redundant for a South African population. Numerous quotes will be included below in reference to decolonisation, and the South African context, so that the full significance of these themes can be adequately captured. The themes will then be referred to again in Chapter Six. Reference to these factors was stipulated by the psychologists with the following quotes:

*Response 1: In our field with decolonisation.....There is quite a lot of-of openness, because we kind of engaging critically, critical engagements with the theories with the west and what it means to be uh an African or to be a different person in Psychology and how things apply to you. The person-in-context. And we have a 2-year Masters programme, so in the first year the-the-the students do their research and so on and then their clinical training proper begins in year two so our year ones last year had um there was a-a huge thing they were like decolonising everything and so on, how does this apply, whole lot of attitude and everything and we actually ended up having to go to get a mediator to sort out the class dynamics and dynamics with us as staff. One of our department staff has training in the critical Psychology field and kind of looking historically*

*at Psychology and so he's thought about what it means for example when people talk about African psychology*

*Response 2: We can talk about gender and identity and we can talk about intersectionality and we can talk about decolonialisation, but I think in a way we can't talk about spirituality really. So there are not drivers and I don't think the system allows it either.....keep asking people, what do you consider the canon in Psychology to be? And without fail, with very few exceptions the response from psychologists...."what do you mean the canon??"*

*They don't know the term, you know, so what is the canon in Psychology, like you know what in any country should psychologists be expected to know. Not believe, to know. (The fact that psychologists generally cannot answer as to the canon of Psychology was expressed in a tone of disbelief and disillusionment. The last sentence, "not to believe, to know" was also emphasised by the respondent by stating that his acquiring knowledge does not have to equate the relinquishing of personal value systems)*

*Response 3: So we need this openness, we need the talk, talking about and it must start when people are being trained. So this whole component, spirituality and religiosity that whole dimension needs to be incorporated, integrated more into the curriculum. People must be confronted, opened up, you must question, you must talk.....*

*Response 4: I think it's a matter of competence. In South Africa people feel they don't have the competence, you know, what do you do? The place you see I think in South Africa where it's coming in is around cultural competence. With the growing awareness that you've got to train people in cultural competence, you've got to, particularly with the whole African-isation of Psychology that you have to be aware of the role of African culture. African culture is so inherently religious and spiritual that the moment you start to open your mind to having to deal with African culture, you can't avoid religious and spiritual issues, because that's so inherently religious that you know most of that is about ancestors and you just you can't not deal with religious issues so I think it's been more, it's probably been black psychologists who came to work at the University who have had a strong cultural interest and they start teaching stuff*

*about cultural but imbedded in that is a strongly religious and spiritual component, and I think that's where you're starting to see more expertise. Now if I work with a black person I'll say to them "do I need to know something about your ancestors"? Do we need to do anything? You know have you done the rituals. Do you believe in ancestors? If so are you praying for your ancestors? And that's exactly like spirituality. It's creating a place in a person's life for this bigger reality.*

*Response 5: Uh there's a big kind of buzz around decolonisation but Psychology is a colonised thing... there's no other way so I can't see.... But I think what decolonisation is talking about is the relevance of that (example given here is religion and spirituality) in Psychology, I think that's what we need to start to move towards...*

*Response 5.1: with black-academics on panels now they very religious and for them it will resonate well if someone says "I belong to a church"*

*Response 5.2: in '94 there were less than 8% of psychologists that were black and when I'm saying black I'm talking about coloured, Indian and African so 92% were white right so you got predominantly white who being selected. At the moment it's still not even 50/50 you know it's still predominantly... so it I think it was pure... it was determined, because you had more Christian coming there, and again depending on the panel, if they were trying to see religion as something that was uh wrong and contributing to the mental illness then they would not... and I think that, that's more white Christian kind of thing (the view that religion might contribute to mental illness)*

*Response 6: At UNISA there's a very strong - the ISHS - the religious beliefs system and incorporating and training and way of looking at the world in terms of community and community psychology and the decolonising work it (religion and spirituality) is absolutely embedded (this participant was not from UNISA)*

*Response 7: and I started my career in the African black community where it was, and you know twenty-five years ago or whatever it is now it was impossible to leave that (religion and spirituality) out. In fact, it was one of the very early questions who has helped you, have you been to a traditional healer, have you been to a Sangoma, what did they say? Bringing that conversation on board,*

*because otherwise you are hitting your head against a brick wall so I think I have allowed myself to see that as a potential partner in working with people from a psychological perspective.*

*Response 8: I think if we compare us where we are at now with 30 years ago we are more open and again from feedback I got from black psychologists and some of them approached me at the conference that I spoke at in psychotherapy and applauded me actually for bringing in religion and they said it's such an important part of healing and they want to hear more about that approach in psychotherapy. I think we have maybe an upcoming generation from other cultures that will be more open and it comes from their spiritual awareness, the fact that they are very aware that spirituality plays a big role in how we function. So I think there's a change coming but it is because there is a total new group of psychologists rising up, not because we have managed to change old mindsets.*

From the responses above, it can be established that the movement of decolonisation may well give opportunity for religious and spiritual perspectives to be given greater consideration in the reworking of curricula. Response 8 is an example of where there is hope articulated for the field of Psychology in South Africa through the empowerment of a new generation of psychologists to be heard and to evoke much needed change in the creation of fresh mind sets.

### **3.3.1.1 Communication and openness**

This subcategory is also applicable to Theme Four, because the use of communication and an attitude of openness were both mentioned in relation to minimising, generalising and stigmatising. Therefore, these concepts will be woven into other discussions as well. In order for there to be intradisciplinary integration of religion, spirituality, and psychology, the psychologists thought it would be necessary for there to be a higher level of communication between professionals. This would have to take place both within departments, and within training environments so that students could partake in such conversations. An openness towards integration would clearly be required, however, there would also need to be an openness to a multitude of faiths and religious groups. The constitution does not allow for discrimination against any religion or spiritual position in South Africa, and therefore psychologists would have to be open to acquiring and disseminating knowledge about an array

of these religious or spiritual positions. As two of the psychologists aptly stated when considering openness within the field of Psychology:

*Response 1: My experience in the discipline is that, I think we are quite xenophobic ... I think we are quite intolerant of ideas*

*Response 2: Psychologists can become quite rigid in their own belief systems in Psychology.*

If the discipline of Psychology truly is xenophobic and rigid in its belief systems, then perhaps that should become the primary focus of communication and openness, otherwise there will be very little communication and openness around contentious issues like religion and spirituality. As mentioned in the previous section, in Response 2, one does not change your personal value or belief systems purely by learning about those that differ from your own. The acquisition of knowledge should not be viewed in a threatening light; rather, it should be seen as the development of professional and cultural competency.

### ***3.3.1.2 The redress of stigmatisation and prejudice***

Although this subcategory has been included in this section of intradisciplinary integration, stigmatisation was such a focus of the data, that it formed a theme on its own. Therefore, the majority of the discussion around stigmatisation and prejudice will follow in Theme Four. For the purposes of intradisciplinary integration, however, it must be noted that the psychologists did not think that effective intradisciplinary integration would be possible without a deliberate effort to redress stigmatisation. Secondly, prejudice and discrimination has marred our country for decades, with the residue of that marring still visible in our society. Integration, by its very nature, requires a position where prejudice and discrimination can be subsumed by equality and acceptance. Therefore, in order for equality and acceptance to flourish, stigmatisations and prejudices have to be uncovered. Further discussion on this will follow in Theme Four.

### 3.3.2 Interdisciplinary integration

Similarly to the pastors, the psychologists expressed a desire to form collaborative relationships across disciplines in order for the integration of religion, spirituality and psychology to be a productive one. As discussed in Theme Three, the “in vivo” term “unnamed conflict” was used to describe a sense of intradisciplinary tension around religion and spirituality more than it was used to refer to interdisciplinary tension. There was a recognition, though, that the “unnamed conflict” may spill over into interdisciplinary dynamics too. As seen in Chapter Four, the pastors referred to the worlds of psychology and spirituality as being “worlds apart”, connected only by spindly bridges. Although the psychologists did not use the same nomenclature to describe this dynamic, they did use language whereby the latent meaning would point towards a similar feeling of being “worlds apart”. Four psychologists used the following phrases to express this: “it is like we are opposite camps”, “we don’t speak the same language”, “we are fundamentally positioned differently”, and “we are sitting on two opposite sides of the fence”. A fifth psychologist relayed an event that he had been involved in where the pastor spoke about the field of Psychology in terms that implied its foreignness to Theology. There was one psychologist, however, who shared her positive experience of working alongside pastoral counsellors at a clinic. This relationship was a collaborative and mutually beneficial one, which the psychologist was pleased about. The meaning in these quoted phrases and vignettes depicting “worlds apart” would suggest that the psychologists share a sense of alienation and distance between the disciplines of Psychology and Theology.

For the psychologists, the distance between the disciplines stemmed from some specific experiences that they had had within the context of church involvement. The majority of the psychologists relayed vignettes of times when they felt that the church, pastoral staff or lay counsellors had had a detrimental impact on their clients (Section 1.2.1). I did not think it was necessary to list or repeat the details of these vignettes, but there are two aspects to this perception that are noteworthy. Firstly, some of the psychologists thought that the church still showed high levels of “cultural incompetence” in which the nuances of racial diversity, power inequality and discrimination are perpetuated, sometimes knowingly, and other times unknowingly. Secondly, the majority of the psychologists stated deep concern over the nature of lay counselling that often takes place within church contexts. Some of the counsel given was deemed to be misguided, with counselling interventions or techniques performed falling significantly outside the scope of practice for the lay counsellors. For interdisciplinary

integration to proceed as smoothly as possible, the psychologists felt that it would be helpful to have conversations about the concerns that both professions may have.

The psychologists did not mention many ways that their profession ought to change in order for collaboration to occur, but they were in agreement about some basic principles that should be in place for interdisciplinary collaboration to proceed:

*Table 28  
Shared Roles and Responsibility of the Pastor and the Psychologist*

<b>Shared Roles and Responsibility of the Pastor and Psychologist</b>
1. Communication and open-mindedness between the disciplines should be encouraged, including opportunities for pastors and psychologists to learn about one another's professions.
2. Pastors and psychologists should foster working relationships with one another where misconceptions and misunderstandings can be openly discussed.
3. Professionals should respect one another and the diversity that the two professions bring.
4. There should be an acknowledgement of the mutual ground in which the professions overlap so that one another's roles can be understood.
5. Instead of maneuvering for territorialism, both the pastor and the psychologist can share the goal of developing people.
6. An increased capacity for objectivity should be developed in pastors and psychologists so that there is a realisation that both professions can add value, but both professions can also cause harm.

One of the psychologists felt particularly strongly about the perceived tension between Theology and Psychology. This was as a result of him having been on the receiving end of dismissive and un-affirming responses from pastoral staff regarding his profession as a psychologist. He used passionate language to express his desire for this tension between the two disciplines to be shifted by saying the following:

*I also think that the collaboration between church and Psychology would come about out a lot easier if there was less anxiety about power and control and so, I mean, if you think about the psychologist, a psychologist is supposed to be neutral and all of those things and if the church just can understand that, you*

*know, like I'm really not here from Satan and trying to change your ideas in a particular way, you know, then that ... if there's a process of demystification, it would go a long way, by the same token for Psychology, you know, it's if there's a demystification around prayer and divinity and how people think about that.*

The use of the word “demystification” is a salient one, because it accurately emphasises the notion that there is a sense of mystery from each discipline towards the other. This can become a breeding ground for misconceptions and stigmatisations, and therefore it is worth the process of demystification if that brings greater enlightenment. One psychologist expressed the integration of his approach to interdisciplinary and intradisciplinary integration in this analogous way:

*I think my.... the way I work with clients is to have it where religion and spirituality and psychology is braided (together) in a healthy way.*

As shown in Chapter Four, some of the pastors stated that they felt dismissed and invalidated by psychologists at times. In the interviews with the psychologists I inquired about this finding so that the psychologists could give their comment accordingly. Three psychologists raised their concerns that psychologists are dismissive of the church at times, not recognising them as a legitimate and valuable part of a healing process. This was expressed by a psychologist in the following way:

*Interviewer: Are there times that which Psychology as a profession can be dismissive of the church and the pastoral as well?*

*Psychologist: Absolutely, yes I think that happens more often than we would like.*

Although the psychologists provided numerous examples of where the church, pastoral staff or lay counsellors may have been unhelpful to psychological processes, there was an overriding recognition of the fact that collaboration remains paramount. This interdisciplinary integration would require the laying down of preconceived ideas and an openness to the development of co-created ones instead. Intradisciplinary integration was similarly an area in which there was aspiration towards progression. One of the enemies of this

progressive integration is the existence of stubborn stigmatisations that seem to prevail. In order to discuss the findings of both sets of data in a coherent manner, the last theme for the psychologists will be similar to that of the pastors in considering how stigmatisation interrupts integration.

### **Theme Four: Stigmatisation**

In Theme One there was an exploration of the perceptions of the psychologists towards the field of Psychology. It was clear from that theme, and the themes that followed, that there are stigmatisations that exist when it comes to the realms of religion, spirituality, and psychology. As shown in Chapter Four, stigmas exist within both disciplines, and it is these stigmas that interfere with intradisciplinary and interdisciplinary integration. The redress of stigmatisation and prejudice was identified in Theme Three of this chapter as being one of the prerequisites for effective and ethical integration to proceed. Before stigmas can be redressed, however, they should be examined and fully understood. This theme, therefore, considers the stigmas that were found in the data and how these stigmas impact effective integration.

#### **Category 4.1.: Stigmatisation of Christianity in Psychology**

In Theme One, it was mentioned that a few of the psychologists differentiated their perceptions of religion and spirituality in general terms in comparison to their perception of Christianity. Some of the psychologists spoke about their own perceptions of Christianity while other psychologists reported on how they thought Christianity was perceived by the field of Psychology in general:

*Table 29  
Perceptions of Christianity Described by Psychologists*

<b>Perceptions of Christianity Described by Psychologists</b>
<i>Response 1: A lot of people actual are quite anti and I don't think it is anti-religious, I think it is anti-Christianity. Yes, I think it is anti-Christianity. I've picked it up to a lesser extent with Islam, but I think for those two groups or those theological systems, that's where the resistance has been most.</i>

*Response 2: The aggression in how people attack a Christian position, because it's not the same, I mean I have seen how in the institution their responses to, for example a Muslim student to a Hindu student, practicing Hindu student very different from the reaction to Christians students so it makes me think that there is something over and above whatever we are doing there, so that's where the spiritual aspect of the things that we do, the institutions in which we find ourselves in kind of - for me - becomes important um ya, because people seem to think you're an idiot that you're a Christian in order to be a Christian you have to be an idiot.*

*Response 3: It might just be my personal interpretation but it is it was against the Christian, Christianity*

*Response 4: We never speak religion. The funny thing is it's become almost politically incorrect to mention Christianity but it's okay to speak about Muslim faith or even African belief systems so if we ever speak about any kind of religious matter it would be about the Muslim faith or the African traditional beliefs but nobody opens their mouth about Christianity unless it's saying something negative about a student or a patient or whatever.*

These four responses imply that there may be a different perception of Christianity than there is towards other religions. These were the four responses where the manifest meaning was the most prominent. There were two interviews where the psychologists answered “yes, Christianity” when asked if there were any religions that seemed to be perceived more negatively than others; the psychologists then followed that answer with an explanation of why they think that this is so. As can be established in the above four responses, Christianity is less favourably received by professionals in those Psychology departments or institutions than what other religions are. Response 4 refers to the fact that Christianity is seen as being politically incorrect within that specific department, which will be discussed in more detail in Category 4.2. The responses that follow indicate the times when psychologists recognised this dynamic and stigmatisation either through interactions within faculties, or with students and/or colleagues:

Table 30  
 Stigmatisations of Christianity Described by Psychologists

<b>Stigmatisations of Christianity Described by Psychologists</b>
<p><i>Response 1: When I was trained I really got the impression that my colleagues all sort of looked down at me, because I'm a Christian. In my group as a master student, that was many years ago was one other Christian and we will immediately sort of when we discover each other, because I was very open about it, because I didn't really expect it the stigma or the sort of negative response so when I think back at those days I think yes it was already there in a group of students that if you're explicit about your religious beliefs that your colleagues would think you know what is wrong with you and I don't know if that has changed so much over the years you know.</i></p>
<p><i>Response 2: I think there was resistance against really allowing them (applicants who are professed Christians and trained at a Christian institution) into a counselling or a clinical Master's programme.</i></p>
<p><i>Response 3: In in academic institutions, it's hard for...in situations... to tolerate Christianity, they can tolerate every other thing or to tolerate religion per se so the, the conflict is there and students often feel like they have to give up that that part of their identity in order to be good psychologists so part of my own position has been to stand with them and say you don't have to, this is who you are it's an important part of who, it's a key part of who you are do not, whatever you do not give that up.(said with a tone and expression of sadness and frustration that students feel this way).</i></p>
<p><i>Response 4: I have had colleagues say to me I don't understand how you're an intelligent person how can you be a Christian, um and it-it does make people think that of you and...and I think that's where some of the conflict comes in... .. because of the institutions in which we work. It used to hurt me a lot and um it enraged me, it did produce all sorts of responses in me but I actually had to come to terms with the fact that we (colleagues) are coming at this from different perspectives and positions.</i></p>

*Interviewer: Have you ever found that students try to hide or mask their religious beliefs during the selection processes for Masters?*

*Response 5: You know I, I find, I think, I think it's understandable, because students who are applying feel they need to fit in to something that is completely so liberal and permissive that anything should go and that any of their own belief systems that they have or value systems..... that is just not ok shouldn't be a part of them.... see, I think they see that but maybe in Psychology maybe this is what we are transmitting, that it will show that they are not as evolved and mature as developed as other clinicians, I think part of it may even be the way that in undergrad we having people think about how you have to be a certain type of person to be able to be a psychologist*

*Response 6: I'm talking about let's say about twenty-five years back there was a strong white liberal kind of thing in the Psychology faculties, so things like religion were always seen as you were not sufficiently educated and that type of thing*

*Response 7: I've sometimes seen students who have picked up is very religious, whichever orientation it is, and when they go quiet and they start withdrawing and their performance starts dropping then I wonder about that.*

*Interviewer:*

*Do your colleagues speak openly about their own faith? What they ...*

*Response 8:*

*No, nobody does. Again we have a couple of Muslim people and they will drop various things, small little tidbits about their own faith, but nobody else will...*

*We speak very comfortably about people's cultures, but we do tend to shy away from religion.*

*I have had relationships with other institutions where I have seen more openness. So it's interesting that the different institutions have different cultures.*

*Response 9: I think what happens then is that Psychology or practitioners of Psychology who do value spirituality and the church simply go underground.*

*And so there's an implicit agreement, there's an implicit understanding..... "I don't like to talk about it"*

*Response 10: We have with our Masters selection we ask people what leadership they've been engaged in and a colleague who always will jokes about this.... "I don't want those psychologists that say that they taught Sunday School" ..... and I am like, you know what that is treating it as a homogenous group. Churches are very different. Sunday schools are very different. You know there are some people who get up there, and they're "speaking to", and then other places that would be a very flexible space. You know, and yes, so for me it's the lack of engagement, you know, so, why would we always said that life line personal growth course is better than get involved in youth work or church work or faith-based work. For me, the answer is always how a person talks about it.*

*Response 11: There's a lot more nervousness and agitation about the how we call the more traditional Christian denominations in our country um I just think it probably goes along with development and uh and what was instilled at some point uh where you have the man in the black suit standing up there authoritarian and preaching fire and brimstone and hell uh instilling fear and nervousness and anxiety*

In Section 1.2.1.1. the theme of rigidity was considered in relation to the valence that psychologists associated with religion, spirituality and Christianity. Rigidity was included in that specific subcategory because of how the psychologists linked that word to their perceptions. However, it could have just as easily been slotted into this current theme of stigmatisation with equal relevance. It is necessary to notice, therefore, that rigidity is as much a statement of valence as it is an indication of possible stigmas that exist in relation to the religion of Christianity. When reviewing the responses that have been included in Table 30 above, there is evidence to suggest that Christianity can be stigmatised in various ways, and in various contexts. Within faculties and departments there may be a hesitation to discuss Christianity in favourable terms, with the result being that colleagues who do subscribe to the Christian faith become more silent about this belief. This behavioural pattern might be replicated in how students respond, either by hiding their religious beliefs, by becoming silent, or by assuming that their faith must be relinquished in order to be accepted as legitimate psychologists. Although the majority of the responses above referred to the Christian faith, a few psychologists implied that this stigmatisation is equally true of other faiths. Response 6 implies that certain stigmas around religion and spirituality may have been more entrenched and engrained 25 years ago, but that there has hopefully been progression since that point. This

hope was echoed by Respondent 8 in Section 3.3.1 who said that the future of Psychology lies in the development of new mindsets that depart from the old ones. In three interviews, the underlying assumption was that the field of Psychology was becoming more open to religion and spirituality, and Christianity. In the other 6 interviews, the psychologists felt that Psychology was perhaps becoming more open-minded about the role of religion and spirituality, but that there was still much nervousness and apprehension surrounding it, particularly Christianity.

The responses referring to stigmatisation were thought-provoking in their content, and became the catalyst to asking why these stigmas might exist. The manner in which the psychologists described these stigmas implied that the roots of the stigmas were germinated within the context and socio-political history of South Africa. This made me ask if the stigmas are indigenous to South Africa, and if so, why? Therefore, the next subcategory further probes this quandary.

### **Category 4.2: Stigmatisation that is Indigenously South African in Nature?**

Of fascination in reading through each of the transcripts was the fact that every psychologist interviewed made reference to Apartheid and the history of South Africa in relation to the integration of psychology, religion, and spirituality.

The presence of the stigma of religion and spirituality, in particular Christianity, was linked to how religion was used during the oppression of Apartheid. One of the psychologists made this compelling statement regarding her perception of the overlap:

*Yes, stigma, there's definitely stigma and there's definitely more stigma attached to Christianity as if there's almost a sense of 'if you're still a Christian after all this, you haven't yet woken up'. So yes one, there is a sense it must come in very subtly. Very quietly and know its place and not assume the voice of authority again. It's the guilt of what is perceived as the oppressor.*

In this response, the psychologist uses “all of this” to refer to everything that has taken place in the history of South Africa. Christianity, therefore, needs to come in “subtly”, “quietly” and “know its place”. The implication being that Christianity has to be contained and restricted so that “it does not assume the voice of authority again”. The authority that it once assumed was misused and abused; the authority was a destructive force that caused substantial anguish. It is for these reasons that the psychologist believes that Christianity as a religion

carries immense guilt, and by implication, responsibility for much of the religious motivations of the past. In this way, Christianity can be used to cause oppression if it does not “know its place”.

There were other responses that referred specifically to stigmatisation within the South African context:

*Table 31  
Stigmatisations of Christianity Described by Psychologists Continued*

<p><i>Response 1: I think that we have been taught that somewhere along the line we all remember a lecturer or someone saying you don't talk about religion or you don't bring it in maybe not in so few words, but it was implied in many of the lecturing and courses so I think it's almost a product of a generation that came before us and that is maybe part of our history in South Africa. You don't want to through everything into the bucket of apartheid but I think a lot of things were governed back then, you don't talk about certain things, in certain contexts, you don't go there, I mean this is how things are but it's been 20 years on now and I think - a lot has changed - I think religion and cultures has entered more into the academics but I think there's still a lot of room for those kind of perspectives and I think we have the backing of our own constitution behind us. Our Constitution then also helps us to say but we can also understand diversity and make room for diversity but we shouldn't make as if it doesn't exist, because then we will be stepping back into this heritage of apartheid era - acting as if things don't existing or it's not happening when actually it is there right in front of our eyes.</i></p>
<p><i>Response 2: So I think the church has been unfairly blamed for a lot of bad in history but I also think a lot of bad in history was caused by actions or choosing not to act by the church.</i></p>
<p><i>Response 3: That comes from our history and from dogma and from master, who's in control, who's the boss, who's got the power, uh which doctrine, which religious doctrine has got the say that informed our politics all this time... ..there's still some... with our history, there's still some remnant of that and, and there's still a struggle</i></p>
<p><i>Response 4: I think it's just a context of this country, white Christianity, and it's also the Apartheid kind of influence of the way we have selected and trained in all of that ...</i></p>

*Response 5: I think that's where the cynicism comes from. It's the practices. And I think it's irregular wrong practices. You know that's uh, I mean the church executed Copernicus for saying the world was round, so I think the crusades, I mean Apartheid, I mean how can it... you know so ya there's need for cynicism around religion (said within the context of cynicism preventing crusading from taking place indiscriminately)*

*Response 6:*

*Interviewer: Do you think that the way in which religion and spirituality is perceived in our country has anything to do with its socio-political history?*

*Response: Well we had a government of, what was it? Christian Nationalism....So... (non-verbal indication of agreement here)*

*Response 7: Certainly in my experience it's (religion and spirituality) come across in a political framework....while in political life with our racism and oppression*

*Response 8:*

*Interviewer: So, then, in terms of that history (RSA) do you think that there is a nervousness around religion?*

*Response: Oh very strong one around that ...*

The frequency of responses that linked religion and spirituality, specifically Christianity, to South African history demonstrates an inherent stigmatisation. The data revealed this stigmatisation both in manifest statements and interpreted latent meanings. This theme dominantly presents the presence of stigmatisation and therefore has to be incorporated into the recommendations that follow from this study. It is accepted knowledge that any religion or religious position (for example atheism which is still a religious position in its nonbelief in the existence of God) has the potential to produce radicalised, fundamentalist and oppressive teachings or practices. However, only two psychologists referred to that when they were speaking about the stigmatisation of Christianity. This was done through a simple comment for example “as with any religion”, and “Islam is also an example of a religion that can produce radicalised adherents (ISIS)”, or “not just with Christianity”. Although the psychologists may have thought inwardly that any religion can become radicalised, it struck me that not all of them stated this overtly. The absence of that disclaimer left me wondering if their perceptions about the radicalism of Christianity were similar to the radicalisation of other

religions. This was unfortunately outside the scope of this study, however, there were two responses that advocated for a second perspective on the role of the church and Christianity within the South African context. Both of these respondents had been segregated and marginalised during Apartheid:

*Response 1: I think religion has had a very, has a curious history in our country from my perspective and it was built very strongly used to justify racial and capitalist oppression in the form of apartheid but it was also used very strongly to oppose it and so Beyers Naude, the Kairos documents, Wilgespruit where they had the first support committees here in Johannesburg, the Catholic Bishops Conference, Kimla which is a very powerful Muslim group, all use religion very strongly and draw on their faith and what the faith meant as opposing it. Alan Busack and his speeches. I think it's from both sides that religion played a contesting role. There is no one now that is going to say that religion, that we are using religion to oppress. And there's no one who is going to contest that religion and faith and belief was a vehicle to look at the anti-religious roots of apartheid and that it was enforced.*

*Response 2: Christianity in the middle ages was harsh and people were killed. It showed in Africa, had a big role in creating Apartheid but also overturning Apartheid and so, and that nuances have been lost. So there's a way which faith ... practitioners of any faith are seen as a homogenous group and lose the nuance of levels of representivity within the faith belief system, levels of practice, levels of conviction, you know, that ... I think that's it. I think that it has been quite difficult.*

What we see through this subcategory is the juxtaposition that begins to emerge within the South African context. On the one hand, there is an association of hostility towards religion, because of the calamitous way that it contributed towards Apartheid. On the other hand, there is a recognition of its role in activism against the practices of Apartheid, and of its inherent value and indispensability to South African culture. Perhaps then, it becomes a question of defining the parameters of the religion of Christianity for this nation, and defining the valence thereof. The implications of the valence and parameters of Christianity within a South African context will be discussed in Chapter Six.

### **Category 4.3: The Way Forward: Redressing Stigmatisation**

Having established that there is a stigmatisation of Christianity that is informed by the socio-political history of South Africa, I would want to know how this impacts the way forward for integration. In Theme Three the desirability of openness and communication within the discipline of Psychology was emphasised as a way to pave the road for effective integration. Similarly, the psychologists frequently stated the requirement for professionals to engage in honest dialogue about some of these sensitive issues. The response below represents and summarises the collective view of the psychologists who felt that dialogues about these sensitive topics should ensue:

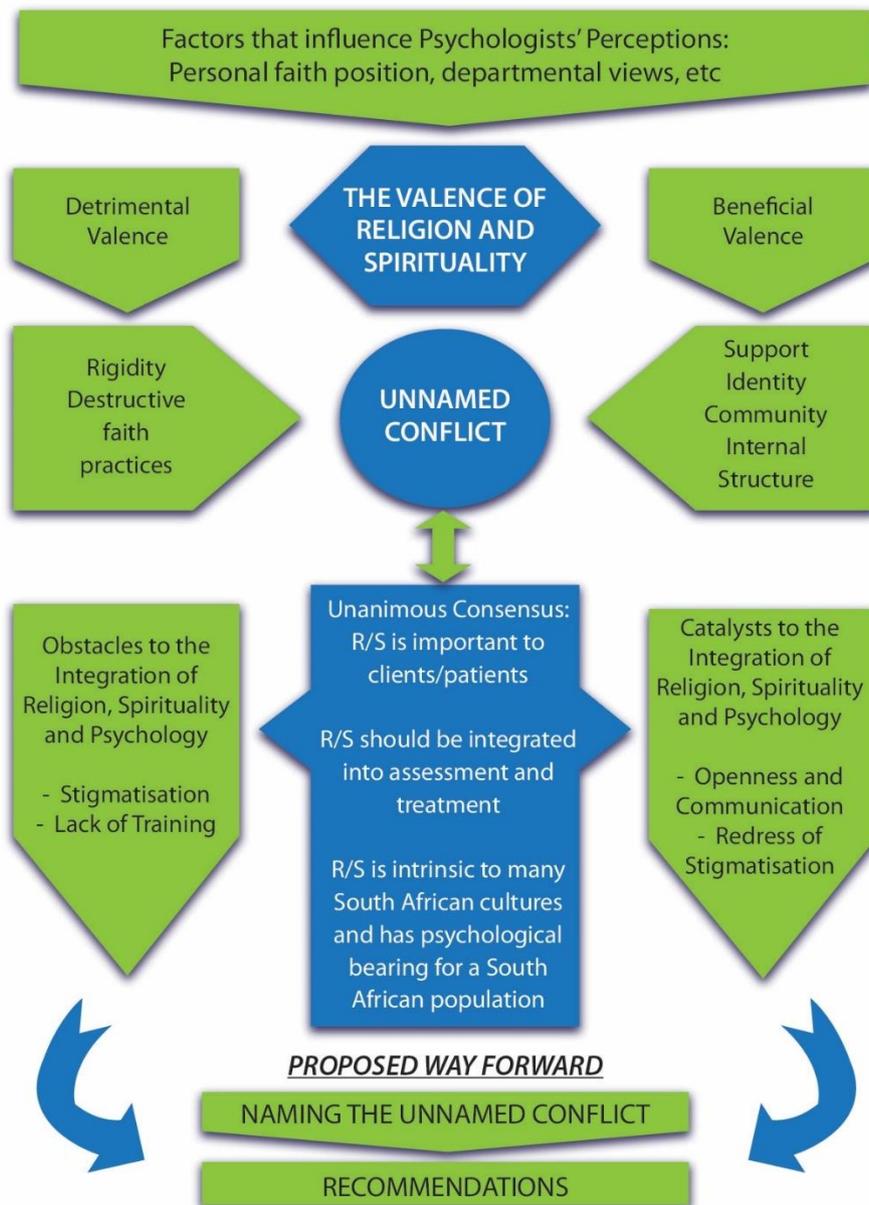
*Response 1: We can speak about black cultural systems and so on but we are not allowed to speak about white cultural systems. It's just not. We've had our turn on the center stage, we must now wait on the wheels. Which is sad in a way, I mean I can understand how that has come about, but what makes it sad for me there could be a rich conversation there. There's a point of connection there but at the moment it's too sensitive. I don't see why it should remain (the sensitivity). It probably may remain sensitive for years to come but I don't see why it should. I think people would be open to speak about it, to engage around it if it was raised in a sensitive way with the acknowledgement of the connotations to the past and so on. And bring it in as not as a voice of authority which I think it was used as previously but as a voice of faith, as voice of meaning for certain people.*

Response 8 in Table 31 highlights the fact that various faculties have differing cultures in how they approach religion and spirituality, which is an important point to be cognisant of. These findings cannot be generalised to all faculties, psychologists or psychology students. What these findings can demonstrate, however, is the possibility that these stigmas may exist in other settings similar to the settings in which they were reported. In this way, we open up the possibilities for future research to develop where the presence and nature of these stigmatisations can be explored more thoroughly. We can also begin to ask the more controversial questions that we may have been ignorant of, afraid of, or arrogant about. The data for the psychologists yielded an enormous amount of information, and were rather overwhelming in its density at times. It was layered with manifest and latent meaning, nuances and inferences.

**Conclusion**

**Thematic Map: Figure 5**

In considering a conclusion fitting for the portentous nature of the findings discussed in this chapter, I will depict the findings and the consequential conclusion in diagrammatic form by using a Thematic Map. This Thematic Map, Figure 5, structured the themes into findings, and then allowed for conclusions to be drawn from these findings:



*Figure 5: Thematic Map of Psychologists' Perceptions*

## THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH

This diagram represents the essence of the findings for the psychologists. The psychologists perceived the valence of religion and spirituality in divergent ways due to various influencing factors. This led to the perceived valence that spirituality and religion was either detrimental or beneficial to the well-being of clients, depending on the circumstances around those perceived valences. Regardless of the experiences that had led to the psychologists' formation of these perceptions, they were unanimous in agreement about three essential principles:

1. R/S is important to clients/patients;
2. R/S should be integrated into assessment and treatment; and
3. R/S is intrinsic to many South African cultures and has psychological bearing for a South African population.

The recognition of the salience of religion and spirituality, however, did not automatically translate into the effective integration of religion, spirituality, and psychology. The space between the recognition of salience and the actual integration of these realms was a space often filled with tension. This perceived tension was present both within intradisciplinary and interdisciplinary integration efforts, and was referred to as the “unnamed conflict”. Regardless of the valence that psychologists attributed to religion and spirituality, and regardless of the tension that may have been felt, the psychologists were still in agreement that there should be more integration of religion, spirituality and psychology. A few obstacles to this effective integration were identified, including the stigmatisation of religion, spirituality and Christianity within a South African context. In order to move forward through these obstacles, the psychologists suggested some catalysts in fostering both intra and interdisciplinary collaboration. The underlying principle of all the catalysts towards integration, however, was founded on the development of attitudes of respect and openness. This openness would only be nurtured in an environment of mutual sensitivity and honest communication, and would have to be developed in both academic and clinical settings. In this environment there would need to be dialogue and discussion about many contentious issues such as South Africa's socio-political history, diversity, racism, prejudice; and the stigmatisation of religion, spirituality, and Christianity. Although this would entail some discomfort, it would be essential to identify, name, and examine these issues so that greater levels of understanding and insight could be created. Therefore, the main vehicle of evoking

change would be to **name** this **unnamed** conflict, and through the naming of this conflict, co-creation of resolution would be conceivable.

### **Concluding Thoughts**

A full review of the findings will be considered in Chapter Six. For the purposes of concluding this chapter, however, I would like to comment on some of the findings and the personal impact thereof.

Firstly, the data obtained from the psychologists were extensive and took numerous hours to code and interpret. Barring one pastor's interview that lasted 220 minutes, the psychologists' interviews averaged at about 40 – 60 minutes longer than those with the pastors. This is most likely because I am also a psychologist and it felt as if I had a “shared language” with the participants. The conversation seemed to flow more easily, because we had a common foundation of training in place, whereas that was not the case with the pastors. With this shared language and foundation, the interviews seemed to be dense with material, because time did not have to be spent on the explanation of concepts, which the pastors felt they had to do.

That being said, I felt a higher level of personal nervousness when conducting these interviews, because each psychologist was older than me, had obtained a PhD, all but two of them were professors, and all of them held respected positions in their faculties. In layman's terms, I felt like a student once again. I also felt the weightiness of the intradisciplinary judgment referred to in section Theme Three, because I knew that my position as a psychologist and as a Christian was known by them. The very dynamic inferred by the use of “unnamed conflict” was the inner conflict that I experienced. Perhaps this is also why this term struck me, and remained in my thoughts throughout the coding procedure of this study. This is most likely why it took centre stage in the concluding diagram, because it held such descriptive value.

The data that impacted me the most powerfully was the discussion on Christianity and Apartheid. In Chapter Two, Section Two, I went to great lengths to provide information about my own history and my existential reality. When beginning with the data collection phase of this study, I was two weeks shy of my thirty-third birthday, while the average age of the participants was fifty, which made me seventeen years younger than the psychologists I was interviewing. So, although I carry a deep awareness of this nation's history, I was ten/eleven years old in 1994, unlike most of the psychologists whom I interviewed. Therefore, my age during this time in our history may have made my understanding of events more limited. Considering this, and the context of, and exposure to political activism that I was raised in, I

did not anticipate the finding of how strongly Apartheid would feature in this study. I am, however, more than willing to humbly concede that it may have been pure naivety that prevented me from predicting this outcome. As mentioned, this was not a finding that I expected to uncover so prominently. I had to take some time to consider why I had been surprised by this finding, and why I had not anticipated it. I spoke to two supervisors, one colleague, and one educator who had been an activist during the Apartheid era. One of the supervisors, and the colleague, was a similar age to me and stated that they were equally surprised about this finding. However, the second supervisor and the educator were fifteen – twenty-five years older than me, and were not at all surprised by this finding. I have often times overheard white South Africans in my generation making comments in reference to racism such as “it’s over now, we all need to move forward”, “it wasn’t even us who caused this”, or “why does everything have to be about racism”. However, reviewing the data of this study has caused an internal shift to occur in which I ask myself if I can even begin to understand the ramifications of our past. Although a few psychologists made statements like “*we are twenty years on now*”, it was not stated as an attempt to undermine the reality that we still face in South Africa today. This has left me wondering if my generation is ignorantly naïve, overly optimistic, poorly informed, or even arrogant about how the remnants of Apartheid are still deeply entrenched in the field and practice of Psychology. Perhaps this is why decolonisation of the curricula remains paramount, because these are themes and dynamics that we ought to dialogue about, be cognisant of, and respectful in; hence the ultimate conclusion of “Naming the Unnamed Conflict”. This will be discussed thoroughly in Chapter Six.

Lastly, I have been left wondering how Christianity in this contemporary society can be represented in a way that does not become reminiscent of the past; how this generation will establish new mind sets and new relationships that become uniting rather than cyclically fracturing; and how we can build the person-in-context theory into the curricula to the extent that religion and spirituality’s valence is no longer an enigma. These are the inner debates that have been born in my mind as I have grappled with this data. I do not have answers to these questions, but I certainly have been left with many more questions than when I started. I wait in anticipation for the prospect of further exploration, research and inquiry into these debates.

**CHAPTER SIX**

**DISCUSSION AND CONCLUSION**

**Introduction**

**Section A: Tabulation of Research Questions and Findings**

**Section B: The Injuries of Secularism: The Perception of the Pastors**

Discussion 1: Injuries of Secularism: Discomfort, Defensiveness and Tension

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**Section C: The Shift Towards Post-Secularism: The Perceptions of the Psychologists**

1. Varying Definitions of Religion and Spirituality
2. Varying Experiences of the Interface of Religion, Spirituality and Psychology
3. Varying Perceptions of the Valence of Religion and Spirituality
4. The Stigmatisation of Religion and Spirituality
5. Varying Approaches to the Integration of Religion, Spirituality and Psychology

**Section D: The “Two Worlds” and the “Unnamed Conflict”: The Inherent Meaning**

**Section E: The South African Landscape: Idiosyncratically formed Meanings and Perceptions**

Discussion 1: The South African Landscape: The People of South Africa

Discussion 2: The South African Landscape: The People of South Africa and Client-Focused Therapy

Discussion 3: The South African Landscape: The Hope of Decolonisation

Discussion 4: The South African Landscape: Redressing Stigmatisation

Discussion 5: The South African Landscape: The People of South Africa: Redressing Stigmatisation

## **Section F: Modus Vivendi: The Way Forward**

### Discussion One: A Modus Vivendi Within the Discipline of Psychology

1. The development of standardised ethical codes and procedures for the consideration of religion and spirituality in the assessment and treatment of mental health or wellness.
2. A comprehensive and culturally-inclusive definition of religion and spirituality for the South African context.
3. A position statement for the field of Psychology in South Africa that delineates a standardised standpoint on the interface of religion, spirituality and mental health.
4. A recognition of and commitment to ethical collaboration with religious and spiritual professionals in a shared common goal for the holistic wellness of people.
5. Continued research on this subject matter in order to generate data that is specific to the South African context.
6. Formalised curricula for undergraduate and postgraduate psychological training that incorporate the above-mentioned points.

### Discussion Two: The Modus Vivendi for collaboration between the world of the pastors and the world of the psychologists

1. Clarifying agendas and confirming definitions.
2. Terminology and scope of practice.
3. Establishing the role of culture, religion and spirituality in different communities, and obtaining the different perspectives of particular faith traditions or belief systems on health and mental health.
4. Providing information on evidence-based management of serious psychiatric conditions (risk factors, symptoms, diagnoses, treatment) to spiritual advisors/workers and to patients.
5. Taking measures to ensure compliance, destigmatisation and optimal outcomes of psychiatric treatment.

## **Section G: Concluding Thoughts**

## **Introduction**

Before the main findings of the study can be discussed, I want to review the primary and secondary research questions that were included in Chapter Two to summarise the answers to these research questions. The table in Section A lists the research questions for this study and provides the sections and/or chapters in which they have been addressed.

In Section B, the perceptions of the pastors will be integrated so that a coherent review of the main findings can be created. Section B has been named “The Injuries of Secularism” to capture the commonality of the main perceptions that the pastors shared, and the manner in which these perceptions were discussed with me.

In Section C, the perceptions of the psychologists on religion, spirituality, and mental health, and the integration thereof, will be summarised in a similar manner to Section B. Section C has been titled “The Shift Towards Post-Secularism”, as the flow of the pastors’ perceptions to the psychologists’ perceptions can be paralleled to Chapter Three. In Chapter Three, the concepts of secularism and post-secularism were discussed as the theoretical point of departure for this study, and therefore the conclusion and discussion of the perceptions will be embedded within that theoretical framework.

As mentioned in Chapters Four and Five, there were two “in vivo” codes that were captured in the data. These “in vivo” codes were used by the participants to give meaning to the internal conflict that they felt when it came to the discussion of religion, spirituality and mental health. The term “two worlds” was coined by a pastor to give voice to his sense of distance and alienation from the world of mental health. The term “unnamed conflict” was coined by a psychologist to indicate her internal turmoil with integrating religion, spirituality and mental health. Considering that these “in vivo” phrases were met with shared meaning amongst the other participants, and that the phrases were metaphorically vivid, picturesque, and illustrative of the latent meanings of the experiences of participants, I have chosen to allocate a section to these “in vivo” codes, which will form Section D.

Flowing from Sections A, B, C and D comes the prominent and almost palpable characteristic that many of these perceptions are idiosyncratically grounded within a South African milieu. This finding requires a section that is independent from the previous sections, so that the nuances of the South African context and the implications thereof can be effectively, but concisely, expatiated on. This will form Section E and will be titled “The South African Landscape”.

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Section F will then ask the fundamental question of “what now”. To borrow from Habermas (2008), the term “modus vivendi” will be used to consider the integration of religion, spirituality and mental health. Through the use of diagrams and tables, the essential conclusions and discussions from the preceding sections will be summarised and categorised in a manner that delineates an answer to “what now”, through the provision of a suggested modus vivendi.

This final chapter will be concluded with a personal reflection of the impact that the research had on me as the researcher and on the participants.

### Section A: Research Questions and Corresponding Information

The primary research question and the secondary research questions were all addressed throughout the findings and conclusion chapters (Chapters Four, Five and Six). For ease of reference, a table containing the research questions with the section where those questions were discussed follows:

*Table 32*

*Tabulation of Research Questions and Corresponding Findings*

<b>Research Question</b>	<b>Chapter Providing Applicable Information</b>
How do Christian church leaders and psychologists perceive the role of religion and spirituality in mental health interventions for clients?	Chapters Four and Five
What are the perceptions of Christian church leaders on the field of Psychology? What are the perceptions of psychologists on religion and spirituality?	Chapters Four and Five
How do the perceptions of Christian church leaders and psychologists impact the role that religion and spirituality plays in Psychology?	Chapters Four, Five and Six

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What impact do the perceptions of Christian church leaders and psychologists have on the psychological treatment of religious/spiritually inclined clients?	Chapters Four, Five and Six
What impact do the perceptions measured in the research have on the efficacy of the field of mental health services and service delivery to clients for whom religion and spirituality is important?	Chapters Five and Six
Should psychological and psychotherapeutic interventions be more inclusive of religious and spiritual beliefs of clients?	Chapters One, Three, Four, Five and Six
What are the differences and similarities in the perceptions of the psychologists towards various faith traditions (Hinduism, Buddhism, Traditional African Beliefs, and Christianity)?	Chapter Five
What are the perceptions of the psychologists and the church leaders towards one another and how does this impact interdisciplinary collaboration?	Chapters Four, Five, Six
Is the field of Psychology in South Africa sensitive and adaptive to a person's constitutional right to freedom of religious expression?	Chapters One, Three, Four, Five and Six

This table indicates that the research questions proposed in Chapter Two were each examined and were comprehensively answered throughout the thesis.

### **Section B: Injuries of Secularism: The Perceptions of the Pastors**

As described in Chapter Three, the movement of secularism was one where religion, religious expression, religious influence and religious authority were sequestered to the private realm of individuals' lives, rather than being afforded public influence (Habermas, 2008; Lombaard, 2016, Lombaard et al., 2018). This gave rise to the development of secular societies where anti-church attitudes were rife, and there was an overt separation of church and state (Van de Veer, 2014). Scientific knowledge was assumed to be grounded within naturalistic, verifiable and observable data which were devoid of religious influence (Brissett, 2006). In this way, a "Big No" to religion was synonymous with human maturity and enlightenment (Lombaard, 2016). When considering this historical era, I am left wondering what the impact thereof has been on religious professionals. With religion and religious influence being suppressed, the impact of this suppression should be reviewed in the lives of religious professionals in order to gain understanding of their lived experiences. Through a careful analysis of the data presented by the pastors in this study, some of the emerging themes seem to parallel the impact of secularism through their existential experience of being regarded as redundant or marginalised by professionals in other disciplines. Therefore, I have titled this section "The Injuries of Secularism", so that I can review the possibility that the pastors' perceptions have been partly shaped by this process.

#### **Discussion 1: Injuries of Secularism: Discomfort, Defensiveness and Tension**

As mentioned in Chapter Four, not only did the interviews provide rich information through the discussions that took place, but many of the dynamics that were present in the interviews were non-verbal, and thus more complex to articulate in this study than the overt statements that the pastors made. Some of these dynamics will be discussed in this section in order to illustrate the findings from this study that indicate possible injuries of secularism for the pastor participants.

When conducting the interviews, eight of the nine pastors displayed discomfort and varying levels of anxiety with the subject matter. This was demonstrated by their physical behaviour for example, shuffling in their seats, and through their own vocalisation of the anxiety they felt. For some of the pastors, the discomfort was more embedded in the subject matter that we were discussing; they often felt as if they had a high level of ignorance or lack

of knowledge, for which they would apologise. For other pastors, the discomfort they felt was more oriented towards the interactions between me and them. One of the pastors illustrated both forms of this discomfort through the following exchange:

*Pastor: ... the Holy Spirit that you know guides you and leads you through that... There's already a sign of conflict coming here for me ...*

*Interviewer: Why do you say a sign of conflict?*

*Pastor: ... Holy Spirit ... not wanting to use those words ... May I?*

This pastor hesitated to use the words “Holy Spirit” in my presence, because he was not sure if he was “allowed” to use religiously based terminology, showing his reluctance and nervousness to speak openly. There was an inherent fear that his reference to religious terms or overtly religious material would be met with my disapproval, or my misunderstanding.

Some of the pastors felt uncomfortable, because they did not think that they could speak my “language”, and apologised for their ignorance. This reiterated that the interface of religion, spirituality and mental health was one that was still enigmatic for them, and required much development.

As mentioned in Chapter Four, many of the pastors acknowledged that the church has frequently reacted to their perceived sequestration from the public realm by becoming territorial towards, and disparaging of the field of mental health. By their own description, their discomfort has, at times, expanded into a defensiveness which has been unhelpful and unfair towards professionals in the field of mental health. At other times, this discomfort and disapproval has led to them distancing themselves from acquiring knowledge of the field, or discussing mental health matters amongst themselves, which has resulted in a deficiency of knowledge.

### **Discussion 2: The Injuries of Secularism: Redundancy and Marginalisation**

As mentioned in Chapter Four, one of the pastors used the metaphor of feeling as if the realms of Christianity and psychology were “worlds apart”, with very few bridges linking those worlds.

This was further indicated by the fact that the pastors would frequently reflect on the feeling of being out of their depth when it came to dealing with issues of mental health, which left them feeling disempowered. The very fact that the world of Christianity was seen as separate and distanced from the world of psychology or science seemed to be indicative of secularism’s drive to remove religion from a place of public authority or influence, thus forcing it to form and inhabit a world distinct and disconnected from the mainstream world. This was further evidenced in a perception that appeared throughout the transcripts: how the pastors felt misplaced by the world of mental health, almost as if this world had made their own world of religion and spirituality a redundant one.

In Chapter Four, Theme One, Category 2 the fears and concerns that pastors had about the field of mental health and the other “world” were reviewed. These included glorification of the individual, the formation of dependency, the role of a functional saviour, and abdication of responsibility. The overarching thread throughout these categories can be summarised as the perception of the pastors that their role in the lives of their congregants and in the healing process of mental distress is often side-lined, and rather deferred to professionals. Professionals become “functional saviours” instead of the congregants drawing strength from their faith, or from their communities of faith. The pastors, therefore, lose some ability to fulfil their pastoral roles and responsibilities towards their congregants, which leads to the perception of their expendability. When reviewing Category 1.2 of Chapter Four, the pastors often seem to feel unseen, replaced, marginalised, and overlooked as legitimate resources or partners in the holistic healing of the congregants. However, this has not diminished their commitment to their congregants, and many of the pastors seem to be resolute in their obligation to provide spiritual counsel.

Table 15 summarised the foundational beliefs that the pastors share regarding the interface of religion, spirituality and mental health. Of interest was point 5 that mentioned the following:

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*Pastors have a specific spiritual responsibility to take care of their “flock”, the congregants under their care. This responsibility is to be taken extremely seriously and includes safe-guarding congregants from counsel that is unbiblical. It also extends to ensuring that their responsibility is not abdicated to an outside professional, but rather that they retain their responsibility to the congregants by a continued involvement in their lives.*

The pastors’ commitment to their role as pastors, as described above, was seen by them as being a commitment to the spiritual calling that they had received from God to enter into pastoral ministry. Therefore, it is a commitment that the pastors held with reverence. This responsibility was justified and authorised by the majority of pastors either quoting Bible verses, or using words from those passages of Scripture which read as follows (in the New International Version):

*Hebrews 13:17 New International Version (NIV)*

*<sup>17</sup> Have confidence in your leaders and submit to their authority, because they keep watch over you as those who must give an account. Do this so that their work will be a joy, not a burden, for that would be of no benefit to you.*

*1 Peter 5:1-3 New International Version (NIV)*

*To the Elders and the Flock*

*1 To the elders among you, I appeal as a fellow elder and a witness of Christ’s sufferings who also will share in the glory to be revealed: 2 Be shepherds of God’s flock that is under your care, watching over them - not because you must, but because you are willing, as God wants you to be; not pursuing dishonest gain, but eager to serve; 3 not lording it over those entrusted to you, but being examples to the flock.*

Considering that the pastors in this sample take biblical Scripture as their infallible truth, it is clear that they would place much importance in fulfilling the directives of the above Scriptural passages. This would include having authority, watching over their flock, giving an account to God of their duties to their flock, shepherding, caring for, serving and being an example to their congregants. If the congregants respond by not consulting their pastors, or by relegating pastors to a place of insufficiency in favour of professionals, then it is understandable

that the pastors may experience a sense of being marginalised or pushed to the periphery of the congregants' lives. In the light of the fact that the pastors think that, much of the time, it is spiritual distress that manifests as, or overlaps with psychological symptoms of distress, their peripheral involvement brings feelings of frustration. This is because this marginalisation would become an obstacle to holistic healing, which the pastors perceive as being as much in the spiritual realm as any other realm of functioning. Although the pastors were immovable on conditions under which they would collaborate with mental health professionals (see Chapter Four), eight of the nine pastors reiterated their desire for collaboration to ensue so that the distance between the worlds could begin to diminish. This collaboration would reflect a more holistic approach in which the "world" of religion and spirituality could be legitimised as a valuable and indispensable partner in the holistic healing of individuals.

The manner in which the vast majority of the pastors discussed the above points indicated to me that there was a distinct recognition and acknowledgement of the "world" of mental health. Furthermore, the pastors demonstrated a genuine willingness to be active collaborators in the process of holistic healing. It is my opinion, based on my discussions with the pastors, that their defensiveness, anxiety, or discomfort with the world of mental health stems from the injuries they have sustained at the hands of that very world, and not from a refusal to build bridges between the worlds. This has led to the formation of perceptions that caused a further disconnection, for example the perception that psychologists and mental health professionals are anti-religious, discussed in Theme One of Chapter Four.

Therefore, from the pastors' perspective, in order to knit together these worlds, a few factors have to be considered:

- Pastors want their "world" to be legitimised through a process of holistic healing for their congregants, which includes the religious and spiritual realm;
- The religious and spiritual aspects of a person's life must be understood as being of equal value and influence to the other realms (for example, psychological and biological);
- It is imperative that healthcare professionals understand the extent to which pastoral staff may feel a sense of responsibility for the care and mentoring of those in their congregations;

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- It is necessary that healthcare professionals have an understanding of the pastor's foundational frameworks and their "world" when collaborative processes are underway; and
- There would be merit in healthcare professionals gaining insight into the possible ways that secularism has influenced religious professionals, so that these patterns of behaviour are not blindly repeated.

To illustrate the findings from Chapter Four, and the points discussed in this section, I will provide a diagram to describe, bring enlightenment, and give expression to the pastors' world. In the Thematic Map, Figure 4, two possibilities were posed on the pastors' willingness to form collaboration between the two worlds. Considering that eight out of the nine pastors discussed their desire and willingness to form collaborations, the figure below depicts the world of those eight pastors who shared this perception. Therefore, it must be noted that the other possibility exists, of not desiring any form of collaboration between the "two worlds", which would prohibit efforts to bring further integration of the disciplines:



*Figure 6: The World of the Pastors*

This diagram summarises the main factors that influence the world of the pastors, as described by them in the interviews. Their world includes the duties and responsibilities that they subscribe to in their role as pastors, for example, the pastors are committed to the well-being of the congregants and they feel that it is their responsibility to ensure this well-being. The pastors have formed perceptions, however, about the world of mental health, and the distance between these worlds. Thematic map, Figure 4, indicates how these perceptions were formed, and Figure 6 above refers to the fact that the world of the pastors is impacted by these perceptions. The pastors each expressed how they had experienced tension or disconnection between their world and the world of mental health, which I have discussed as the “Injuries of Secularism”. These injuries involved them feeling marginalised from filling an important role in their congregants’ lives in reference to their mental health. This marginalisation left the pastors wanting to be recognised and legitimised in their role as religious and spiritual advisors for their congregants, instead of being assumed to be redundant. These injuries have, at times, resulted in a defensiveness towards the world of mental health. However, despite all of these perceptions, injuries and defensiveness, eight of the nine the pastors were earnest in their willingness and desire to collaborate with mental health professionals.

### **Section C: The Shift Towards Post-Secularism**

Had it only been the pastors whose experiences and perceptions could be paralleled to secularism and post-secularism, the argument for this parallel would have been construed as weak. However, it was the data from the psychologists’ transcripts that provided the richest analogous depiction of this parallel. This was evidenced by a few central themes within the data that will be elaborated on briefly in this section:

1. Varying definitions of religion and spirituality;
2. Varying experiences of the interface of religion, spirituality and psychology;
3. Varying perceptions of the valence of religion and spirituality;
4. The stigmatisation of religion and spirituality; and
5. Varying approaches to the integration of religion, spirituality and psychology.

The above five themes are each illustrative of how secularism has influenced the current prevailing attitude of ambivalence in the participants when it comes to the subject of religion, spirituality, and psychology.

### 1. Varying definitions of religion and spirituality

One of the most obvious findings was depicted in Theme Two of Chapter Five where the perceptions of religion and spirituality provided by the psychologists lacked a unifying, coherent and standardised definition of those terms. This can most likely be explained by the fact that few of the psychologists had received formal training or education in the interface of religion, spirituality and psychology; similarly, few of them incorporated such knowledge in the curricula of their undergraduate and postgraduate Psychology programmes. As a response to secularism, Miller (2003) states that many healthcare practitioners distanced themselves from the subjects of religion and spirituality as being too esoteric to constitute legitimate science, and responded to the separation of church and state by not recognising the importance of religious beliefs in the treatment of their patients. One of the psychologists illustrated this process by saying the following:

*Psychologist: ... because I know there's such a strong continued push to separate faith and science in a sense ... I also think that it's located in Psychology's inherent struggle to be a legitimate science.*

*We are not scientific, if we can't talk about evidence based practice, then we are hop and a skip to Voodoo dolls ... So, I think for me in terms of training psychologists, for me, you know, if I can fall back on a kind of very psychoanalytic idea, empty ins Chris-folderol, and if I consider how this person would function, then I have to consider what his or her spiritual beliefs are.*

The term used here, Chris-folderol, refers to the uselessness of Christian faith or religious belief located in Jesus Christ. This term has a similar meaning to the statement reviewed in Chapter Three of Christianity being “irrelevant speculation” (Van der Veer, 2014, p. 170). Chris-folderol and “irrelevant speculation” both speak to a secularised perception and definition of religion and spirituality which, according to the above quote, has made its way into mainstream psychology/mental health theories. This is one of the processes that may have therefore, resulted in the fragmented academic definition, integration and understanding of religion or spirituality in some academic contexts.

There was, however, a commonality in the perception that spirituality was preferred to religion – either by virtue of the psychologists’ personal perceptions, or as a comment on the perceptions of their colleagues. This gives rise to the next theme of valence, and how the valence of religion and spirituality was perceived.

### **2. Varying experiences of the interface of religion, spirituality and psychology**

Chapter Five, Tables 22 and 23 explained how the psychologists' perceptions and experiences with the interface of religion, spirituality and psychology formed their opinions of valence, valence being the beneficial or the detrimental influence of religion and spirituality on psychological wellness. Some of these experiences were embedded within the psychologists' own faith positions and personal histories, and some of the experiences were with family, patients/clients, training institutions, colleagues or with the pastoral fraternity. Of note was that the psychologists' experiences held much influence in the valence that they attributed to religion and spirituality. Although experience is a valuable source of knowledge and information, it should not be the primary determination of how psychologists interact with religion and spirituality in their professional and teaching capacities. Rather, there should be a standardised and evidence-based, research-informed body of knowledge that provides psychologists with an academically trustworthy theory of the interface of religion, spirituality and mental health. Otherwise, what is known as (anecdotal) "experience" becomes a dangerous ground for the development of transference and countertransference, which can ultimately cause harm to both the psychologist and the patient/client – an unethical scenario.

### **3. Varying perceptions of the valence of religion and spirituality**

In Chapter Five, Category 1.2., the perception of the valence of religion and spirituality by the psychologists was discussed at length. It was determined that religion was mostly less positively perceived than spirituality and that religion, particularly Christianity, was associated with rigidity. Furthermore, the category demonstrated that the term "religiosity" was regularly used by the psychologists to denote a religious fanaticism that was rigid in nature. However, according to Matthews, McCullough, Larson, Koenig, Sawyers and Milano (1998, p. 119) the definition of religiosity refers to the level of religious commitment shown by a person, and as such, "commitment refers to the participation in or endorsement of practices, beliefs, attitudes, or sentiments that are associated with an organised community of faith". This definition of religiosity (Matthews et al., 1998) therefore considers the levels of participation in, and internalisation of a belief system by a person, which is not necessarily related to fanaticism. When the psychologists in the sample defined religiosity, they seemed to merge the definition automatically with an evaluation of the valence thereof, which is problematic.

This difference in defining religiosity in academic sources versus the perceptions of the psychologists further indicates that there is not a standardised and unanimous definition for the

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central definitions of religion, spirituality and religiosity amongst the academic communities. This can result in religion and religiosity carrying the association of a less favourable valence to the term of spirituality. As Tacey (2004) cautions, spiritual narcissism can develop when spirituality is frequently given a privileged and preferential status over religion. It would be necessary to guard against this dynamic in academia by focusing on valence, and not on the relative superiority of religion or spirituality.

That being said, the concept of valence was considered in Chapter One, where Pargament et al. (2013) posit that it is unhelpful to polarise religion and spirituality into “bad” and “good”. It is more helpful to ask the question of when, how, and why religion and spirituality will either contribute to or inhibit psychological wellness. Pargament et al. (2013) make some suggestions for evaluating the valence of religion, spirituality and religiosity; however, this is published within the context of a North American-dominated population and is not specific to the South African context. In order to differentiate the valence of religion and spirituality effectively, it must be socio-politically grounded, and therefore guidelines for determining valence in South Africa requires further research.

As a starting point in determining valence, South African author, De la Porte (2018, p. 1-2) offers the following guidelines provided in the table below as a means of assessing the valence of a client/patient’s religious and spiritual beliefs. The table shows spiritual beliefs and practices that are indicative of spirituality when it is a source of strength, as well as beliefs and practices associated with spirituality that have become detrimental for the client. De la Porte (2018) suggests that clinicians refer clients/patients to pastoral counsellors in the event that there are indications that their beliefs are detrimental to their holistic wellbeing.

*Table 33*

*De la Porte’s (2018) Guidelines for Determining the Valence of Spirituality*

<b>Spirituality as a Source of Strength</b>	<b>Spirituality that is Detrimental in Influence</b>
	The person’s experience of spirituality will be rigid and judgemental.
The person belongs to a faith community that is supportive and wholesome.	The faith community will require a strict adherence to certain rules and practices.

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Activities in the faith community (such as a fellowship group) will provide ongoing support.	Strict rules and practices can strengthen guilt feelings and a feeling of failure.
A worship service is uplifting and creates an atmosphere for positive emotional experiences.	There will be an emphasis on sin and judgement.
A congregation leader (minister/pastor) trained in spiritual and pastoral counselling can provide supportive counselling.	Leaders (ministers/leaders) in the faith community will display rigid and judgemental attitudes.
Outreach and/or service activities in the congregation can broaden a person's experience and contribute to strengthening of self- image.	Images of the transcendent/deity will focus on judgement and punishment.
All of the above will provide a safe space where the person can grow and heal.	These images of the transcendent/deity usually have a strong link with childhood experiences of authority figures.
Psychiatric illness will be accepted and stigma will be broken down.	Abuse by authority figures or even by faith community leaders will result in deep-seated wounding and may be perpetuated in the current spiritual experience of the person.
The person will have a positive experience, relationship and expectation toward the transcendent/deity.	If the person suffers from a mental illness (such as depression or schizophrenia), all of the above can contribute to religious pathology, where spirituality finds expression in different clinical symptoms with a religious overtone.
Images will confirm the compassion of God (father, friend, saviour, companion).	Psychiatric illness will be stigmatised.

From the above table, determining the valence of religious and spiritual beliefs becomes more defined. It is this form of communication between mental health professionals and religious practitioners that could be extremely valuable. Such an intervention could most

certainly assist mental health professionals in understanding the pastoral world, and the world of clients/patients who subscribe to religious beliefs. It would strengthen collaborative efforts between the two disciplines if a shared language such as depicted in the above table (De la Porte, 2018) could be formed between the “two worlds”. The recently developed Association for Christian Religious Practitioners (ACRP), recognised by the South African Qualifications Authority (SAQA), would most likely be able to offer much insight into the discussion of valence, collaboration, and referral. This is a South African based resource that the world of mental health professionals would be wise to incorporate in developing ethical guidelines and curricula for the training of such professionals.

#### **4. The stigmatisation of religion and spirituality**

It flows from the above mentioned points 1 – 3 and Theme Three of Chapter Five, that the stigmatisation of religion and spirituality seems to exist in various forms from both the samples of pastors and psychologists included in this study. With such an obvious distinction in how religion and spirituality is perceived, defined, and experienced, it is understandable that stigmatisation would develop. The psychologist sample, however, differentiated the stigmatisation of religion and spirituality as generally being distinct from the stigmatisation of Christianity. Theme Four of Chapter Five evaluated these stigmas and elaborated in detail on the nature thereof. Some of the stigmatisations seemed particular to the socio-political history and context of South Africa, which will be discussed in Section F, but some of the stigmatisations seemed to reflect a secularised view of religion and spirituality. As reviewed in Chapter Three, secularism developed within a European context, and developed specifically in reaction to the religion of Christianity (Habermas, 2008). Therefore, it is plausible that the influence of secularism has determined how religion and spirituality are conceptualised in mainstream Western academia, which has similarly entered the arena of South African academia. The responses in section Category 4.1, Chapter Five made reference to how secularism may have contributed to the stigmatisation of religion and spirituality:

*Response 1: I know there's such a strong continued push to separate faith and science in a sense.... I also think that a particular challenge is that Psychology is very anxious within itself as a discipline and we spoke a little bit earlier about that, but I think that is a big, big part of it. So I think what happens then is that Psychology or practitioners of Psychology who do value spirituality and the church simply go underground.*

*Response 2: Psychology has been so desperate to be a science you know so we are at pains all the time to set ourselves up as scientists and we want to be accepted by ultimately by physicists, because that's the ultimate science so Psychology has been so at pains to prove that we're a science and you know we don't religion seems so wishy-washy and it's going to undermine our credibility as scientists*

It is with this in mind that I wonder if the current movement of academic decoloniality in South Africa will enter the space of religion and spirituality, which will be reviewed in Section F.

### **5. Varying approaches to the integration of religion, spirituality and psychology**

Having considered the varying definitions, perceptions, experiences and stigmatisations of religion and spirituality, it follows that a standardised protocol for approaching religion and spirituality within the field of Psychology in South Africa is conspicuous in its absence. This was evidenced by the divergent ways that the psychologists integrated religion and spirituality into their psychological practice. A summary of the various stances and practices for integration was provided in Table 27. These stances and practices, however, were developed by the psychologists on an *ad hoc* basis, because the psychologists (bar two, who had been trained internationally) had not been provided with any formal training in this specific subject matter. Of specific interest to me was the fact that only one of the psychologists made reference to the concept of Spiritual Intelligence in their interviews. The concept of Spiritual Intelligence did not seem to factor in their definitions or perceptions of the interface of religion, spirituality and mental health. This is perhaps due to the lack of education and training in this subject area. Although the discussion of Spiritual Intelligence was outside the scope of this study, it should be a focus of further research, especially in reference to the South African context.

Apart from a lack of training on the integration of religion, spirituality and psychology, the psychologists also expressed strong concern about the ethical framework for such integration. This resulted in further divergence in how the psychologists inquired about or worked with the religious and spiritual issues that their clients/patients brought into therapy. Apart from the constitutional right to freedom of religion, and the Health Professions Council's prohibition of discrimination against people on the basis of their religious or spiritual affiliation, there is no ethical statute that specifically addresses how to handle religious or spiritual issues within the practice of Psychology in South Africa. If we are going to progress

from a secularised, Westernised understanding of religion and spirituality to a more post-secular one, then should the academic arena not provide a theoretically supported platform from within which to do so?

The above five points have been summarised from the findings in Chapters Four and Five in order to show how possible threads of secularism have hindered the integration of religion, spirituality and psychology. However, apart from these threads, the dominant narrative amongst both the pastor and the psychologist groups reflected their acknowledgment that integration such as this is essential to the psychological and spiritual well-being of people.

As discussed in Chapter Three, the shift towards post-secularism is evidenced by religion and religious institutions still exerting considerable influence in modern day pluralistic society and in the culture of society (Habermas, 2008). In an interview with Berger (Mathewes, 2006), Berger himself stated that religion should no longer be marginalised and suppressed, but that it should rather be accepted that religion and spirituality make valuable contributions to both the development of sociological theory, and the understanding of humanity. The finding of existential meaning within religious and spiritual domains is becoming more normalised in current society, and the acknowledgement of this phenomenon is far less contested (Lombaard et al., 2018). The healthcare sector has responded to this shift by placing religious and spiritual matters in its sphere of consideration, through models such as the biopsychosocial-spiritual model of healthcare (Sulmasy, 2006). There has been a proliferation of academic research into the interface of religion, spirituality and health, which has also expanded into mental health. Although the majority of this research has been done internationally, the South African academic world is making its own contribution to advocating for religion and spirituality to be assimilated into healthcare practice (see Chapter One for the summary).

The shift from a secularised view of religion and spirituality to a more post-secular one was observable in the data provided by the psychologists, through a few central points of agreement shared by all the psychologists. These points included the following, as mentioned in Chapter Five:

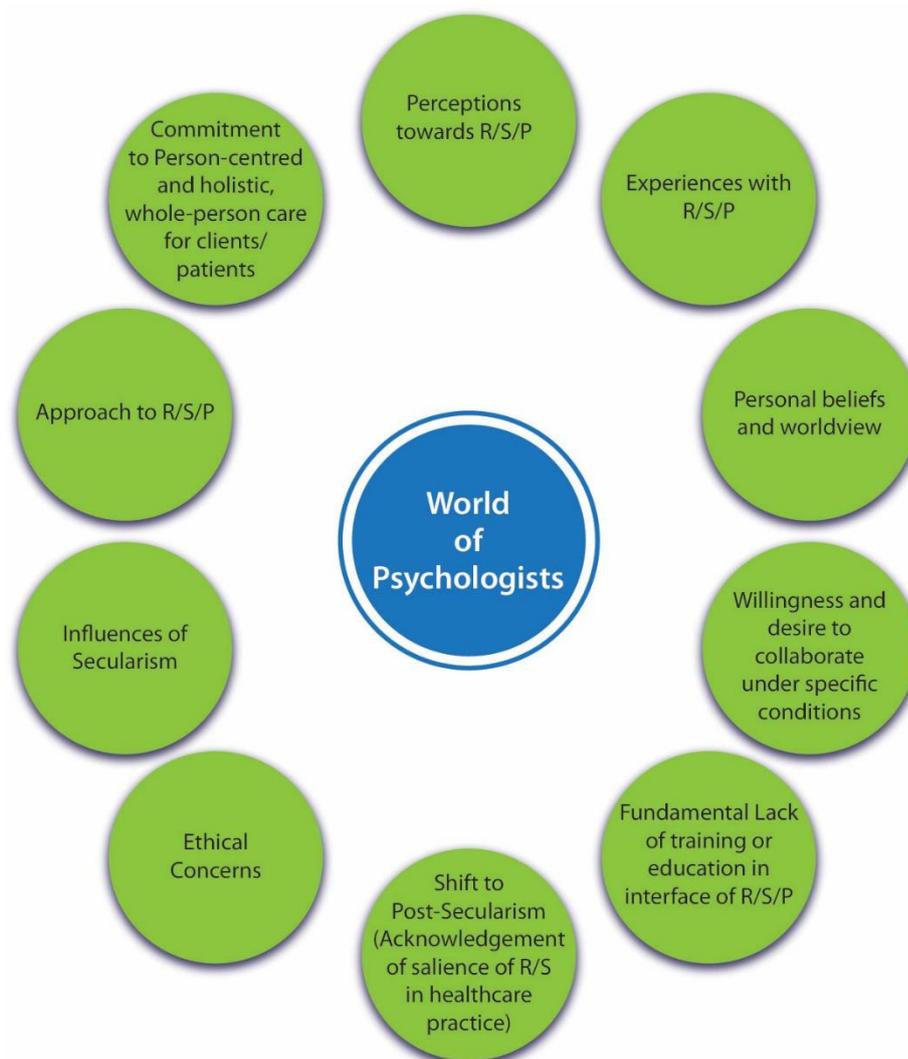
1. Religion and spirituality (R/S) are important to clients/patients;
  2. R/S should be integrated into the assessment and treatment of clients/patients;
- and

3. R/S is intrinsic to many South African cultures and has psychological bearing for the South African population.

These findings are not dissimilar to the findings reported by Peteet, Rodriguez, Herschkopf, McCarthy, Betts, Romo and Murphy (2016) in their sample of psychologists who had shown comparatively higher levels of acknowledgement of the importance of religious and spiritual dimensions in treating clients than psychologists from previous studies and surveys. As mentioned, therefore, this trend may be indicative of a transitioning from secular to post-secular paradigms of thought in the field of mental health.

The border between secular and post-secular seems to be an ill-defined one, one in which there is some ambiguity. As mentioned by the psychologists, in some contexts it seems acceptable to discuss religion and spirituality more openly, while in other contexts it is still met with high levels of discomfort. Perhaps this is the “unnamed conflict”, where there is tension, perhaps even a sense of insecurity or fear of judgement; but also where both religion and spirituality are not only tolerated, but are explored and legitimised. In Chapter Five, it was posited that the primary way to facilitate the integration of religion, spirituality and psychology, would be through the “naming of this unnamed conflict”. Although this will be considered more comprehensively in Section E of this chapter, it is clear that one of the ways that this conflict has to be named is through the lens of secularism, post-secularism, and the impact thereof.

The “world” of the psychologists can be depicted in a similar manner to the “world” of the pastors. Chapter Five described a myriad of ways in which the psychologists perceived the integration of religion, spirituality and psychology, which were informed by various factors. Section B has expanded on these findings and illustrated how the world of the psychologists has been influenced by secularism and post-secularism. Figure 7 below depicts the world of psychologists according to these factors:



*Figure 7: The World of the Psychologists*

The diagram above depicts the primary factors that form the world of the psychologists, as described in the interviews, when it comes to the interface of religion, spirituality, and psychology/mental health (R/S/P). Similarly to the pastors, the psychologists held perceptions about this interface, and about pastors or churches. The perceptions were outlined in Thematic Map, Figure 5 and were primarily influenced by their experiences with religion/spirituality with their practices/clients/patients, within their academic environments, and in reference to their own personal religious or spiritual beliefs. Furthermore, the theoretical approach that was followed by the psychologists had a significant impact on how they approached religion and spirituality with their clients/patients. The influences of secularism seemed to have affected their comfort in integrating religion and spirituality in practice, because of their concern that psychological science should be neutral and detached from religion or spirituality. However, with the shift towards post-secularism, there was an acknowledgement from the psychologists

that religion and spirituality are important to clients/patients; that religion and spirituality should be integrated into the assessment and treatment of clients/patients; and that religion and spirituality are intrinsic to many South African cultures, thus carrying psychological bearing for the South African population. The psychologists expressed their commitment to person-centred, whole-person care for their clients/patients, and conveyed that this ought to be inclusive of religious and spiritual beliefs. There was a willingness from the psychologists to collaborate with pastors and for there to be a process of co-creating knowledge with the pastors so that clients/patients could be effectively treated. However, the psychologists remained concerned about the lack of training in the interface of R/S/P as it could lead to unethical practices, and therefore were unanimous in their opinion that adequate training should be integrated into Psychology curricula.

### **Section D: The Unnamed Conflict and the Two Worlds**

As mentioned in Sections A and B, there were two allegorical terms used by the participants to give articulation to their existential realities within the interface of religion, spirituality and mental health. The term “unnamed conflict” was used by a psychologist, and the term “two worlds” was used by a pastor. This section will review these two terms in order to form a basis for Section E, where the *modus vivendi* will be considered.

When looking at the latent meaning inherent in “unnamed conflict” and “two worlds”, there is a commonality present. Both terms reflect the experience of disconnection, tension, ambiguity and discomfort, without an immediately visible resolution to that experience. The psychologist who coined “unnamed conflict” is a Christian, and used this term to explain the conflict experienced in being Christian within an academic environment that is perceived to be anti-Christian. Not only is the conflict present in that context, but the psychologist made reference to occurrences in which the church had expressed views and opinions that were oppositional to the profession of Psychology and mental health. Therefore, no matter which context this psychologist was in, there was an underlying current of tension, at times. The three other psychologists in the sample who divulged their Christian faith in the course of the interview reported similar experiences in both their professional and faith-based communities.

In Greyvensteyn (2018) I reviewed findings from the pilot study of this PhD study, and found a similar trend in the data obtained from the psychologists who formed part of the pilot

study. One of the psychologists was quoted as saying the following (Greyvensteyn 2018, p. 12):

*The admission of being a Christian and a psychologist seems to create the impression with colleagues that you are, by virtue of being a Christian, no longer a fully-fledged psychologist, and that you are a lesser psychologist, because you happen to be a Christian. There is the assumption that being a Christian somehow interferes with your ability to be a professionally acceptable psychologist.*

This excerpt reflects the same essential tension that is present in the “unnamed conflict”; it shows how psychologists who are Christian may feel a sense of discrimination within their professional realms. The concluding finding about this dynamic found in the pilot study reads as follows (Greyvensteyn, 2018, p.12):

*The participants who echoed this above perception responded by remaining silent about their beliefs, or by being hesitant to discuss their beliefs with colleagues, unless they knew that those colleagues shared similar religious views. This sub-group of participants was particularly concerned about Christian clients whom they had treated, because many of these presented with obvious spiritual difficulties that clearly operated alongside emotional and cognitive factors present in the client’s symptomology. However, because these participants had received little to no training about the interaction between religion, spirituality, and psychology, they often felt ill-equipped to treat these clients as holistically as they needed to be treated.*

It seems as if the above paragraph is as relevant to the pilot study results as it is to the data of the main study. The “unnamed conflict” must, in part, therefore, be attributed to the existential reality of some psychologists who are devout adherents to the Christian faith. This existential experience of the “unnamed conflict” reflects the discussion in Chapter One, where the term *Weltanschauung* was cited by Bilgrave and Deluty (1998) and Peteet (2016). The term *Weltanschauung* was used to rationalise the importance of religion and spirituality as intrinsic to people’s existential, explanatory belief systems and worldviews, which is informed by culture, providing the framework from which individuals create meaning. As Bilgrave and Deluty (1998) determined though, mental health professionals who held strong religious and spiritual beliefs felt as if they had to create a separate *Weltanschauung* for their professional

lives to that of their religious/spiritual lives. This split in *Weltanschauung* had caused a deep tension and discomfort for the psychologists, because they found it challenging to reconcile those two separate *Weltanschauungen*. This experience seems to parallel closely to the discussion in my study which gives expression to the “unnamed conflict” in the “two worlds”.

To explore this theory of whether or not mental health professionals can relate to this experiential reality of a divided *Weltanschauung*, I facilitated a series of discussions with a group of such professionals who are Christian. This group consisted of three psychiatrists, two general practitioners, two clinical psychologists, one counselling psychologist, one educational psychologist, and an audiologist. All members of this discussion group reported times when their Christian faith had been negated, minimised, stigmatised, verbally attacked, patronised or condemned. Not only had they encountered this dynamic in their professional contexts, but each of the health professionals in the group were able to report times when they had been on the receiving end of criticism from their faith communities for their chosen careers. The group members responded to this similarly to how the psychologists in the pilot study responded: by becoming silent about their faith, becoming hesitant to discuss their faith with colleagues, and by only discussing the faith aspects or tensions in their lives with colleagues of the same faith. The group members did, however, report that some of them are becoming more verbal in advocating for religion and spirituality to be integrated into healthcare practice, and for the stigma of Christianity to be addressed. Three of the group members had registered for PhDs that considered the role of religion and spirituality in healthcare sectors, specific to the South African context. The prevailing finding in this discussion group, however, remained that these professionals can relate to the concept of an “unnamed conflict” and the painful tension that this sometimes evokes for them in their professional and faith communities. The experiences of the pilot study psychologists, the main study psychologists and the discussion group members can perhaps here too be captured with the earlier-employed metaphor of “two worlds”. These professionals are aware of the “two worlds”, and they form part of each of these worlds, but it is often required of them to straddle the “two worlds” – with one foot in each world. The feeling of being spread between worlds is not a comfortable one, and is one in which there is a dearth of support at times. Not only was this experienced by the psychologists in this study and in the other sources cited, but this was similarly the experience of psychology students in the South African context, as reviewed in Chapter One (Patel & Shikongo, 2006; Brown et al., 2013; Elkonin et al., 2014; Padayachee & Laher, 2014).

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Therefore, the convergence of evidence would suggest that the “unnamed conflict” holds validity for both professionals and psychology students.

For the psychologists who follow faith traditions other than Christianity, for example agnostic, Muslim, Hindu and Buddhist faith traditions, there was still the reporting of a perceived tension when it comes to the subject of religion, spirituality and mental health. This was thoroughly reviewed throughout Chapter Five, but in recapping those findings, the essential perception was one of nervousness and tension. The psychologists uniformly agreed that religion and spirituality should be considered within the realm of mental health. However, this concession was made within the context of an uncertainty on how best to achieve this interface, while still being cognisant of the underlying valences of aspects of religion and spirituality for psychological wellness. This creates inner conflict for many of the psychologists. Not only is this the case for psychologists, but similarly for other health and mental health professionals, as reiterated by Isaac, Hay, and Lubetkin (2016), who considered the incorporation of spirituality in primary care settings. These authors (Isaac et al., 2016) found that health care professionals acknowledged that spirituality should be incorporated in their practice as a dimension of cultural competency, however, these professionals found this to be a controversial matter. The controversy was related to the valence of spirituality (that it can have both a positive and a negative impact on health), their own personal experiences or beliefs around spirituality, as well as the lack of formal training in ethically interfacing spirituality with health; all of which had led them to feel incompetent in integrating religion and spirituality into professional practice. Although Isaac et al. (2016) did not make use of a specific term to describe the health care professionals’ experiences within this “controversial space” (Isaac et al., 2016, p. 1072) the rich description provided seems comparable to the term “unnamed conflict” used here.

When reviewing the data of the pastors and the psychologists, I reiterate that there is an emergent theme of existential tension for both groups. The tension was described by the pastors as “two worlds”, and the corollary for the psychologists was termed the “unnamed conflict”. As mentioned, although the terms differ, an essential inherent meaning is emulated from both. In this way, the pastors’ “two worlds” resembles the psychologists’ “unnamed conflict”, because there is a discomfort, a tension, and an uncertainty reflected by both terms.

The distance between the “two worlds” is characterised by a few factors, one of which is ignorance or a lack of knowledge. However, despite all the stigmatisations and perceptions

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discussed previously that the pastors have towards the field of mental health, Section B concluded that the pastors (bar one participant) still desire this distance to be lessened. The psychologists similarly recognised the distance between the world of mental health and the world of the pastoral, but were united in an acknowledgement that this distance should be reduced.

Having reviewed the nature of the “two worlds” with Figure 6 “The World of the Pastors”, and Figure 7 “The World of the Psychologists”, the space between those worlds, which is the “unnamed conflict” requires equal examination. This section, Section C, has elucidated how the “unnamed conflict” is formed, alongside the characteristics of this “unnamed conflict”.

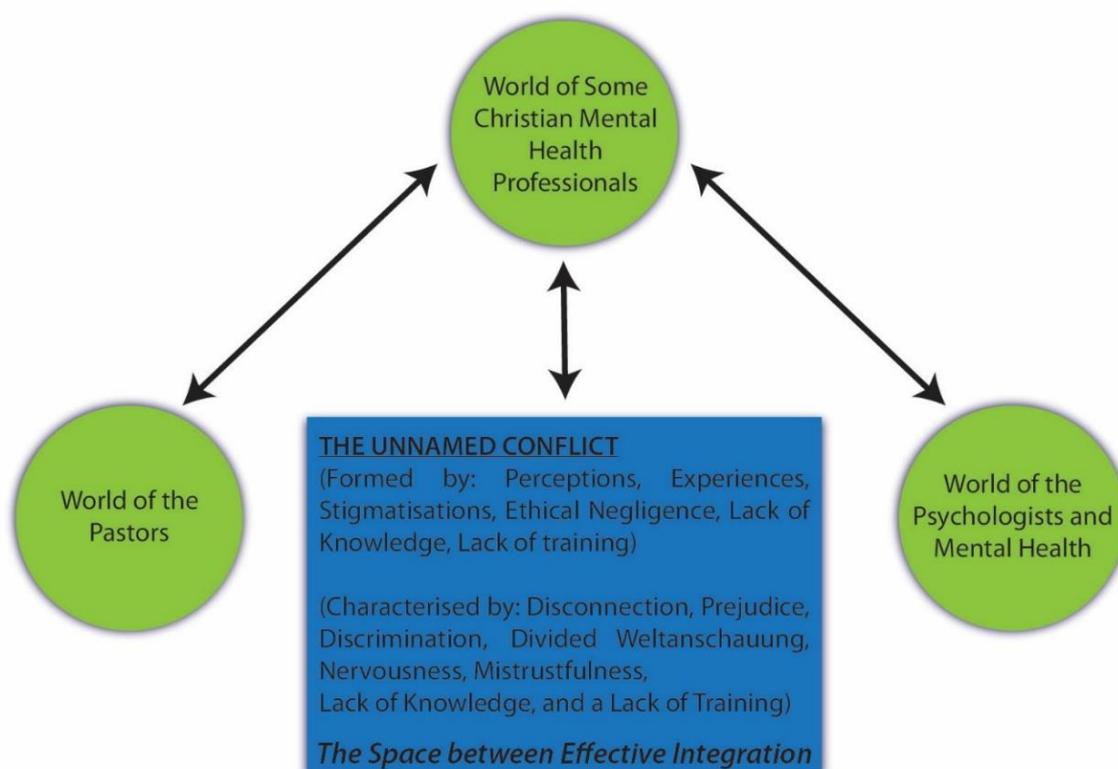
To summarise the discussion up until this point, the “unnamed conflict” between the two worlds is formed through and characterised by the following aspects:

*Table 34*  
*Factors Forming and Characterising the Unnamed Conflict*

<b>The Unnamed Conflict</b>	
<b>Formed Through</b>	<b>Characterised By</b>
Perceptions	Disconnection
Stigmatisations	Prejudice
Ethical Negligence	Arrogance Ignorance
Lack of Knowledge	Divided <i>Weltanschauung</i>
Lack of Training	Nervousness
Experiences	Mistrustfulness
Antipathy	Antipathy

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As discussed in the Thematic Map, Figure 6 in Chapter Five, one of the suggested resolutions in addressing the “unnamed conflict” is to start naming that very conflict. Through an understanding of the formation and characteristics of this conflict, we are able to merge these into a coherent depiction of the “unnamed conflict” and the “two worlds”. Furthermore, the experience of some Christian mental health professionals reportedly having a divided *Weltanschauung*, and thus being straddled between those two worlds in the epicentre of the “unnamed conflict”, can be depicted. It is appropriate then, to name this discussion “The Unnamed Conflict of the Two Worlds”, which can be best shown through the use of a figure:



*Figure 8: The Unnamed Conflict of the Two Worlds*

Figure 8 gives visual representation to a myriad of internal existential dynamics described by the participants, and shows the complexity found between, and within the two worlds of pastors and mental health professionals. As discussed in Chapter Five, the unnamed conflict is formed by perceptions, experiences, stigmatisations, ethical negligence, lack of knowledge and lack of training within the intradisciplinary and interdisciplinary context. This causes disconnection and distance between the two worlds, which is experienced both by the pastors and the psychologists.

The diagram further provides an analogy of the tumult experienced by some Christian mental health professionals who feel as if they “fit” into both worlds, but “belong” to neither. This tumult was described by Christian psychologists in their interviews, and was reiterated by other Christian mental health professionals in the pilot study, and in discussion groups conducted as part of the main study. With this unnamed conflict comes the existential experience of being disconnected and discriminated against, as well as feeling nervous or mistrustful, both within and between the worlds. Some Christian psychologists described this struggle in ways that paralleled the term *Weltanschauung* (referring to their worldviews or beliefs) by saying that they have had to form a professional *Weltanschauung* and a personal *Weltanschauung* in an attempt to feel some acceptance in both spheres. The division in *Weltanschauung* leaves these psychologists feeling as if they do not have full acceptance or belonging in either their professional (Psychology) or personal (faith-based) worlds which results in them being uncomfortably straddled between the two worlds.

The term “modus vivendi” is defined by the Cambridge English Dictionary as follows:

An arrangement allowing people or groups of people who have different opinions or beliefs to work or live together.

Habermas (2008, p. 22) uses “modus vivendi” to evaluate the efficacy of such arrangements that have unfolded in secularism and post-secularism movements. Therefore, considering that secularism and post-secularism inform the interpretation of some of the data in this study, the use of the word “modus vivendi” seems fitting when considering the possible arrangement that could be made in addressing the “unnamed conflict” of the “two worlds”. Section E will explore this further in the proposed modus vivendi for the “unnamed conflict”.

### **Section E: The South African Landscape**

#### **Discussion 1: The South African Landscape: The People of South Africa**

As mentioned in Sections A, B and C, the South African context is a unique one, rich with diversity. In a public address, Dr Mpho Ratshikana-Moloko made reference to the place of religion and spirituality within that diversity and the implications thereof for the South African healthcare sector at the Spirituality and Healthcare Conference, October 2017. Ratshikana-Moloko commented that in her experience within the public hospital sector, she

has found that South Africans are intrinsically spiritual and religious, because many of their spiritual and religious beliefs are immersed within cultural traditions. This proposition of Ratshikana-Moloko (2017) was similar to one by Pastor Sonjica (2018) where he stated the following:

*You know that South Africa is known as a Christian country, there is the Gospel all over. You go to the townships, to the villages, to the cities, to the towns...and you find people....and they all know something about God. You go the villages and to the townships, and someone will start a chorus, and everyone knows it and just gets into it...they just sing, because they have been exposed to the gospel....it is within.*

This pastor and this medical doctor are not known to one another, and come from different provinces in South Africa. They further represent distinct disciplines: Theology and Medical Science. And yet, Pastor Sonjica's (2018) and Ratshikana-Moloko's (2017) statements are, in essence, interchangeable. Both imply that the influence of religion and spirituality is pervasive across South Africa, and that they are inherent in the various spheres of society.

Ratshikana-Moloko (2017) elaborated on this proposition by drawing on her experiences in a management position she holds at a state hospital. She reported that doctors and nurses are constantly faced with their patients' desires for their religious, spiritual and cultural beliefs to be integrated into their healthcare. Ratshikana-Moloko (2017) explained that the nursing staff begin each day with prayer and the singing of hymns in the wards, the patients joining those proceedings by their own choice. Patients frequently refer to religious, spiritual and cultural aetiology when discussing their medical conditions, which requires healthcare staff to be respectful and integrative of these factors. Furthermore, it is not unusual for patients to request that medical personnel collaborate with religious practitioners so that their holistic treatment can be ensured. Ratshikana-Moloko's (2017) main conclusion was that religious, spiritual and cultural dimensions must be integrally interfaced with the healthcare of South African patients; when this interface is facilitated, then cultural competency for an African worldview can be attained.

## **Discussion 2: The South African Landscape: The People of South Africa and Client-Focused Therapy**

Considering the comments provided by Ratshikana-Moloko, and the research cited in Chapter One, we should consider the evidence that South Africa is innately spiritual and/or religious. With this in mind, the preferences and needs of the clients/patients who enter into treatment ought to entail the inclusion or consideration of their religious and spiritual beliefs. If the profession of Psychology and mental health is going to be committed to client-focused psychotherapy, then the client's beliefs become a factor that should be given credence. Norcross and Wampold (2011) identified a number of client factors that should be considered when adapting treatment so that the treatment is as efficacious as possible. The factors considered by Norcross and Wampold (2011), include religious and spiritual dimensions, and how clients “develop, express, negotiate and integrate their religious or spiritual commitment in therapy” (Fuertes & William, 2017, p. 373). On this point, Fuertes and Williams (2017) state that it is essential for clinicians to determine clients' experiences of therapy and what engages or motivates a client so that the psychotherapeutic relationship can be an effectual one. Client variables play the most pivotal role in determining the successful outcome of psychotherapy, because it is both the client's motivation and level of commitment that impact the overall effectiveness of psychotherapy. Fuertes and Williams (2017), therefore, encourage researchers and clinicians to champion the perspective and preferences of the client so that psychotherapy, including the role of religion or spirituality, can be tailored accordingly.

In the most recent comprehensive meta-analysis of the integration of clients' religion and spirituality within psychotherapy (Captari, Hook, Hoyt, Davis, McElroy & Worthington, 2018), results indicate valuable findings, including:

- While some religious or spiritual clients seek psychotherapy that integrates these beliefs, other religious and spiritual clients become circumspect in discussing these facets of their lives in psychotherapy settings that they interpret as being secular;
- Psychotherapy that was adapted to consider a client's religious or spiritual beliefs (R/S accommodative psychotherapy) was found to be more effective for the client's psychological and spiritual enhancement than not receiving any treatment at all, or receiving treatment that was not accommodative of religious/spiritual beliefs. In subsequent additive, more rigorous studies to these, the authors (Captari et al, 2018) determined that religious and spiritual accommodative psychotherapy

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had the same impact on psychological wellness as standard (secular) psychotherapy, but that clients showed higher levels of spiritual well-being when receiving the R/S accommodative therapy than the standard psychotherapy.

Based on these findings from the comprehensive meta-analysis, Captari et al (2018) make the following recommendations for therapeutic practice:

- Clinicians should be aware of the efficacy of R/S accommodative psychotherapy for treatment outcomes and for the psychological and spiritual well-being of their clients;
- Clinicians that adhere to the American Psychological Association's ethical guidelines are required to consider religion as a key component for diversity and the respect thereof (APA, 2017, principle E, as cited in Captari et al, 2018); and
- Avoiding the discussion of religious and spiritual topics with clients becomes counterproductive to the formation of rapport and to the psychotherapeutic relationship, because it implicitly communicates that these areas of a client's existential reality are not significant for psychological well-being. Therefore, clinicians are encouraged to acknowledge the importance of clients' religious and spiritual beliefs and to explore them within "R/S specific ethical guidelines" (Captari et al, 2018, p. 21).

Considering that Norcross and Wampold (2011), Fuertes and William (2017), and Captari et al (2018) identify the accommodation of a client's religious and spiritual beliefs as influencing the efficacy of therapeutic outcomes, this finding should inform the field of Psychology, and should place client-focused therapy such as this at the forefront of psychotherapeutic interventions.

When discussing the above cited research pertaining to client-focused treatment with the health professionals' discussion group mentioned previously, each mental health professional was able to relay countless instances when clients had asked them as therapists to disclose their own religious/spiritual beliefs before the client would make an appointment. The mental health professionals mentioned that clients/patients frequently ask them if they are Christian, because the preference of the client is to be treated by a professional who can "understand" their religious and spiritual positions. Clearly these appear to be factors that are of paramount importance to clients before they enter therapy, and perhaps as they progress in therapy. As Greenidge and Baker (2012) state, religiously committed clients have a marked

preference to work through psychological distress with professionals who are also religiously committed, while those who are highly religiously committed will actually exhibit resistance towards working with professionals who do not share the same level of religious commitment. Greenidge and Baker's (2012) research aimed to explore highly committed Christians' propensity to seek out and consult with committed Christian professionals. The data (Greenidge & Baker, 2012) showed that when consulting with secular professionals, the Christian clients anticipated that the professionals would threaten or challenge their religious beliefs, resulting in a sense of internal tension and inhibition for the client. The data also revealed that the Christian clients showed such a marked preference to be counselled by a Christian professional that it may be "difficult for them to be convinced of the legitimacy of a secular counsellor" (Greenidge & Baker, 2012, p. 220). Peteet et al. (2016) considered a similar research question in their study to investigate whether a therapist's worldview matters for their clinical work. The authors (Peteet et al., 2016) argue that the therapist's worldview has a direct influence and impact on the following aspects of their work: diagnosis (extent to which the diagnosis includes culturally competent care); the formulation of a case (the aspects of the case that the clinician will naturally place more emphasis on), and treatment (how the preferred virtues of the therapist influence their conceptualisation of human flourishing and what the outcomes or goals of the treatment should be). Peteet et al. (2016, p. 1102) therefore state that it is impossible for the worldviews and values of the clinician to have no impact on how they counsel clients/patients to consider the "moral dimensions of choices".

At the same time, however, Peteet et al. (2016) caution that there are specific transference and countertransference boundaries that become more tenuous when the clinician and client/patient share the same religious or faith beliefs. These include an assumption on either the part of the clinician or client/patient that they are in agreement about all spiritual and religious issues, which could cause misunderstandings, or may be used by the client/patient to idealise the clinician believing that this clinician understands them better than anyone else. Furthermore, other boundary transgressions such as what is known in APA and HPCSA ethics as "multiple relationships" (if both are part of the same faith community), or requests from the client/patient for the clinician to pray for them in therapy become ethically dubious. The issue of prayer is of particular concern, because Peteet et al. (2016) reflect that there are very few guidelines that address what can be recognised as part of a therapeutic process; this offers a good example of what was earlier referred to, when discussing the lack of ethical guidelines on the interface between religion, spirituality and mental health in Chapter One, and in Section C

and Section D of this chapter. Nonetheless, client-focused therapy requires the clinician to be responsive to the client/patient's preferences for treatment, within ethical parameters. In reference to the ethical obligation for client/patient preferences to be at the forefront of clinician's treatment protocols, Plante (2014, p. 289) states the following:

To ignore religion as a cultural issue may not only be unethical but also lead to malpractice.

Concerning the South African landscape, if the proposition that the population of South Africa is innately religious and spiritual holds validity, then the tailoring of client-focused therapy should be inclusive of this aspect of functioning. Not only did Ratshikana-Moloko (2017) and Sonjica (2018) imply this proposition, but it was also stipulated by many of the psychologists interviewed in this study. The psychologists mentioned South Africa's religious and spiritual ambience by saying that the black African culture is an inherently spiritual one that weaves spirituality, religion, culture and traditional beliefs into an integrative African worldview. The responses in Theme Three, Chapter Five included quotes that demonstrated this perception, particularly the following five:

*Response 1: One of our department staff has training in the critical Psychology field and kind of looking historically at Psychology and so he's thought about what it means for example when people talk about African psychology*

*Response 2: I think it's a matter of competence. In South Africa people feel they don't have the competence, you know, what do you do? The place you see I think in South Africa where it's coming in is around cultural competence. With the growing awareness that you've got to train people in cultural competence, you've got to, particularly with the whole African-isation of Psychology that you have to be aware of the role of African culture. African culture is so inherently religious and spiritual that the moment you start to open your mind to having to deal with African culture, you can't avoid religious and spiritual issues, because that's so inherently religious that you know most of that is about ancestors and you just you can't not deal with religious issues so I think it's been more, it's probably been black psychologists who came to work at the University who have had a strong cultural interest and they start teaching stuff*

*about cultural but imbedded in that is a strongly religious and spiritual component, and I think that's where you're starting to see more expertise.*

(Note that this excerpt was provided by a psychologist from the Indian culture and was a reflection of how the previously marginalised cultures in South Africa must be given authority in determining the curricula for Psychology so that it is culturally inclusive)

*Response 3: ...with black academics on panels now they very religious and for them it will resonate well if someone says "I belong to a church"...*

(in terms of selection processes for Masters) *and again depending on the panel, if they were trying to see religion as something that was uh wrong and contributing to the mental illness then they would not... and I think that, that's more white Christian kind of thing (the view that religion might contribute to mental illness)*

*Response 4: ...and I started my career in the African black community where it was, and you know twenty-five years ago or whatever it is now it was impossible to leave that (religion and spirituality) out. In fact, it was one of the very early questions who has helped you, have you been to a traditional healer, have you been to a Sangoma, what did they say? Bringing that conversation on board, because otherwise you are hitting your head against a brick wall*

*Response 5: I think if we compare us where we are at now with 30 years ago we are more open and again from feedback I got from black psychologists and some of them approached me at the conference that I spoke at in psychotherapy and applauded me actually for bringing in religion and they said it's such an important part of healing and they want to hear more about that approach in psychotherapy. I think we have maybe an upcoming generation from other cultures that will be more open and it comes from their spiritual awareness, the fact that they are very aware that spirituality plays a big role in how we function. So I think there's a change coming but it is because there is a total new group of psychologists rising up, not because we have managed to change old mindsets.*

These above five responses from the psychologists in the sample reflect Ratshikana-Moloko's (2017) position discussed earlier that South Africans place considerable meaning and value on their spiritual, religious and cultural beliefs. The psychologist participant's opinion in Response 5 above is particularly illustrative of this, as it indicates that old mindsets embedded in psychological or mental health practice may not have disappeared, but rather that there is a new generation of South Africans entering the field of mental health with mindsets that challenge the former ones.

### **Discussion 3: The South African Landscape: The Hope of Decolonisation**

The premise of the decolonisation movement has been to critically consider the suitability and applicability of curricula dominated by Western academia, for the multicultural and pluralistic South African milieu. In a special issue of the *South African Journal of Psychology*, the decolonising of community psychologies was reviewed; this included an introductory article by Seedat and Suffla (2017), who advocate decolonisation. The necessity for the decolonisation of community psychologies to take place is described by Seedat and Suffla (2017, p. 422) as “a space to critique the assumptions and far-reaching influences underlying the dominant knowledge economy in community psychologies, considered to be largely shaped by imperialism, colonialism and coloniality, neo-colonialism, globalisation, and Euro-American ethnocentrism”. Not only is the process of decolonisation imperative for community psychologies, but also for the field of South African Psychology as a whole.

Some of the psychologists interviewed considered the possibility that decolonisation would also entail a reevaluation of the pertinence of religion and spirituality for the practice of Psychology in South Africa. The psychologists hoped that the pinnacle of decolonisation would encompass a methodical comprehension and sensitivity for an idiosyncratically African worldview, filtering into Psychology curricula. The interview protocol used for this study did not include any questions about decolonisation, the psychologists' responses included the spontaneous introduction of this term and the discussion of how decoloniality could potentially change the practice of Psychology in South Africa. The following responses, as shown in Chapter Five, showed a desire for decolonisation to shift the manner in which religion and spirituality are currently integrated into the canon for mental health training:

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Table 35  
Responses Related to Decolonisation in South Africa

Response Number	Quote
Response 1	<i>In our field with decolonisation ... There is quite a lot of-of openness, because we kind of engaging critically, critical engagements with the theories with the west and what it means to be uh an African</i>
Response 2	<i>We can talk about gender and identity and we can talk about intersectionality and we can talk about decolonisation, but I think in a way we can't talk about spirituality really. (Participant later indicates that he thinks decolonisation may provide an opportunity to critically evaluate the relevance of religion and spirituality to South Africans)</i>
Response 3	<i>So this whole component, spirituality and religiosity that whole dimension needs to be incorporated, integrated more into the curriculum. People must be confronted, opened up, you must question, you must talk.....</i>
Response 4	<i>Uh there's a big kind of buzz around decolonisation but Psychology is a colonised thing... there's no other way so I can't see.... But I think what decolonisation is talking about is the relevance of that (example given here is religion and spirituality) in Psychology, I think that's what we need to start to move towards....</i>
Response 5	<i>At UNISA there's a very strong - the ISHS - the religious beliefs system and incorporating and training and way of looking at the world in terms of community and community psychology and the decolonising work it (religion and spirituality) is absolutely embedded (this participant was not from UNISA)</i>
Response 6	<i>In this society in South Africa, it is something that is very important to people. It does come up fairly often. In fact, people use it as part of their identity. They tell you who they are and what they do and what their religion is. What church they go to. So I think we probably should find a way of bringing it into the conversation when we train students</i>

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<p><i>Response 7</i></p>	<p><i>Eighty percent of blacks uh are Christian anyway even if they practice a dualistic African belief so ya it plays a very important role. very often even if patient is admitted into a psychiatric ward we'll give them a pass over the weekend to do a ritual uh, because they believe that what we are diagnosing is schizophrenia and maybe actually that they have not appeased an ancestor so we actually send them over the weekend to go and do that in spite of... so that kind of merging of treatments become important if you want to attend to the psychological and psychiatric needs that individuals have.</i></p> <p>(This response was given by a psychologist who is a black South African, and the use of the term 'blacks' was not used in a derogatory manner)</p>
<p><i>Response 8</i></p>	<p><i>In South Africa we have a large part of our population who does believe in things like bewitchment and curses and trans-generational issues from forefathers and those are real spiritual beliefs and experiences and can't be dismissed as psycho-pathological or dysfunctional but should be taken into account.</i></p>

Not only did the psychologists demonstrate a hope that decolonisation would bring about a review of a psychology that is more relevant to South Africa, but they also recognised that, despite the stigmas associated with religion, spirituality and Christianity, there is still an overarching call for religion and spirituality to be integrated into the psychological understanding of people, as shown in Theme Three of Chapter Five. This indicates the suitability of the biopsychosocial-spiritual model, implied by the responses above, for the South African landscape of professional Psychology. As Ratshikana-Moloko (2017) stated, the only way to treat South Africans ethically is by respecting, acknowledging and interweaving their religious/spiritual beliefs into healthcare practice. To negate this dimension of South Africans would be to negate an essential component of their “existential reality”, which would technically be an unethical approach to their constitutional right to freedom of religion, and to their basic dignity. Of all the universities represented in the psychology sample, only one of them had used an integrative model, for instance the biopsychosocial-spiritual model, part of the curriculum for undergraduate and graduate Psychology programmes as an example of a

model of healthcare that considers religious and spiritual beliefs. One of the participants from this particular university posited that the movement towards decolonisation would potentially legitimate the requirement for this model to be standardised in curricula across the country.

### **Discussion 4: The South African Landscape: Cultural Literacy**

Another of the psychologists linked the concept of decolonisation of curricula to the underlying “cultural illiteracy” in how South Africans in general, as well as within church contexts, deal with multiculturalism. Laher and Padayachee (2014, p. 11) makes explicit reference to a similar matter in her discussion of cultural competence. This term was used by Laher and Padayachee (2014) to give voice to the perception by Hindu psychologists, in South Africa, that therapists in this country must demonstrate “cultural competence” when working with clients from various religious and racial groupings. The perceptions of the psychologists in that study (Laher & Padayachee, 2014) indicated that there are poor levels of cultural competence (Laher & Padayachee, 2014, p. 11) amongst therapists in South Africa. This is shown through, for example, psychologists’ lack of knowledge and training in the cultural aspects of the Hindu faith, and how this is inextricably interwoven with the experience, diagnosis, assessment and treatment of psychological or psychiatric disorders. The Hindu faith and the African worldview are both described as being collectivist in nature, which is not accounted for or understood within the “Western psychological profession” (Padayachee & Laher, 2014, p.12), especially due to Western theories which are individualist in orientation. Laher and Padayachee (2014) further stipulates that most devout Hindus have a pronounced preference to be treated by psychologists of the Hindu faith, because these psychologists are deemed to be more competent in interfacing the Hindu faith with psychological wellness. This contribution of Laher and Padayachee (2014) therefore tends to support the findings reported earlier in this section, that some clients/patients have a marked preference to receive treatment from professionals who can recognise and integrate religious or spiritual beliefs into psychological practice.

This is not entirely dissimilar to Bergin and Jensen’s (1990) term “religiosity gap”, reviewed in Chapter One, as being the disconnection that occurs when a client’s religious and spiritual beliefs are not acknowledged by the practitioner, or are not effectively integrated into the treatment process. In this study, it was shown that the pastors purposefully attempt to counter such a “religiosity gap” through their preference to refer congregants to Christian

mental health professionals, as the assumption is made that those professionals will not perpetuate this gap (see Figure 3, Chapter Four).

Therefore, if we view in parallel these three terms – “cultural illiteracy”, “cultural competence/incompetence” and “religiosity gap” - their commonality is that they show an inherent inability for professionals to accommodate adequately a person’s spiritual and/or religious worldviews. This also links to Section B above, where secularism’s influence was indicated as leading to a repression of and, at times, subversion of religion and spirituality. Perhaps then, the movement of decolonisation in South Africa is representative of facets of post-secularism in which the plurality of cultures begins to necessitate a comprehensive review and integration of such pluralities in society and in academia. I would posit, therefore, that decolonisation will provide a platform from which South Africans can begin to oppose cultural illiteracy and cultural incompetence in favour of culture inclusivism. This inclusivism would naturally account for spiritual and religious factors.

Laher and Padayachee (2016) proposed a model for the South African context to foster greater levels of cultural competence. In this model, stigmatisation was addressed through the education and training of professionals, and through collaboration across disciplines of religion, spirituality, and mental health. This model incorporates some of the factors, perceptions and dynamics that I have found within the data of this study, which further supports the necessity for the fields of mental health to interface more concretely with matters concerning spirituality and religion. The theme of stigmatisation is one that is present in both Laher and Padayachee (2016) and my findings. Therefore, it can be safely concluded that the stigmatisation of religion and spirituality, as well as that of mental health, requires urgent attention within the South African community of Psychology practitioners in order to facilitate efficacious, ethical integration.

### **Discussion 5: The South African Landscape: The People of South Africa: Redressing Stigmatisation**

The findings of this study suggest that some of the stigmatisation of religion and spirituality is rooted within the socio-political backdrop of South Africa. Theme Four of Chapter Five, the excerpts from the psychologists all referred to the complexity of South Africa’s history, and how this is translated into the present. This specific response, as included

in Theme Three of Chapter Five, was provided by a white psychologist, and was stated with a tone of shame, yet with understanding for the origin of stigmatisations:

*Well we had a government of, what was it? Christian Nationalism....So...*

*Yes, stigma, there's definitely stigma and there's definitely more stigma attached to Christianity as if there's almost a sense of "if you're still a Christian after all this, you haven't yet woken up". So yes one, there is a sense it must come in very subtly. Very quietly and know its place and not assume the voice of authority again. It's the guilt of what is perceived as the oppressor.*

As Coertzen (2014) aptly states, Christianity was a religion that received a privileged status in South Africa for three centuries. In 1994, however, freedom of religion was afforded equally to all religions in South Africa. That Christianity had a privileged status to other religions in South Africa prior to 1994, is most likely the major contributing factor to the stigmatisation associated with Christianity. To counter the eventuality that Christianity reassumes such a position of privilege, or "authority" as the above participant stated, Coertzen (2014, p. 141) warns that there must not be a regression from this equal privilege and freedom through "theocratic control by one religion over the whole of society". To prevent such a regression, the state and all religious institutions in South Africa are exhorted by Coertzen (2014) to take responsibility in ensuring that all religions are respected, protected, and given the freedom of religion that is due to them.

The suggestion that Christianity is stigmatised in South Africa due to the role it played in the Apartheid regime is a suggestion that the pastors alluded to as well. In Theme Four of Chapter Four, I reflected on how six of the pastors acknowledged that there are "silences" within the church about certain contentious matters. One of these silences was the complicit role that political agendas stemming from some Christian churches had in perpetuating the monumental injustice and discrimination of Apartheid.

One pastor linked this complicated dynamic to the term "context illiterate", which is closely related to the term "cultural competence", because it captures the difficulty faced by South Africans across spheres of different disciplines; in the pastor's own words:

*And what I mean by that is we now live in uh a South Africa that is changed rapidly in the last few years and the change is happening at a pace that many of us are just struggling to keep up.*

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This particular pastor reflected on the fact that not only is there a complicated interface between Christianity, the socio-political history of the country and mental health, but also that cultural complexity is entangled in this “context illiteracy”. This pastor explained to me that it is often uncomfortable for him, and for other church leaders, to discuss with their elders (in the cultural sense) sensitive issues like marriage or even depression. At times, it feels culturally inappropriate to inquire about the personal and private details of the elders’ lives, or for a member of the younger generation to counsel them. All of these dynamics compound what this pastor described as “context illiterate”.

Considering the above described complexities in the South African landscape, it appears as if Christianity and the valence thereof should be more comprehensively and holistically defined for this country. The psychologists frequently referred to valence in their perceptions of Christianity, but they also acknowledged that their perceptions often contained misperceptions, which necessitated redefinition.

Furthermore, the “silences” that the pastors referred to within the church context ought to be replaced by discussions on vulnerability and restoration. One of the pastors in the sample relayed to me that he had recently considered making an apology from the pulpit, on behalf of the institution of the “church” in general, for the abuses to which Apartheid had subjected South Africans. Another pastor mentioned how he has created multicultural groups in his congregation in which people are encouraged to discuss openly the contentious and painful subjects of race, culture and discrimination. Perhaps these are examples of how communication can be fostered, but with the intention of openness, restoration and mutual understanding. To use the language of one of the psychologists quoted in this data, it is necessary for Christianity and the valence thereof to be co-defined by those who had been oppressed by its influence, and not only defined by those who are associated with that oppression.

In the light of this consideration, the final section reviewing the way forward for the interface of religion, spirituality, and mental health can be introduced.

**Section F: Modus Vivendi: A Way Forward in the Unnamed Conflict of the Two Worlds**

This section will be divided into two main discussions: Discussion 1 will review the modus vivendi for the profession of Psychology; Discussion 2 will review the modus vivendi for collaboration between the world of the pastors and the world of the psychologists.

**Discussion One: A Modus Vivendi within the Discipline of Psychology**

In order for the discipline of Psychology in South Africa to consider ethically the interface of religion, spirituality and mental health, I propose central processes should be in place. These include, but are not limited to, the following six points:

**1. The development of standardised ethical codes and procedures for the consideration of religion and spirituality in the assessment and treatment of mental health or wellness:** In Chapter One, the research cited by Ragan and Malony (1980), Bergin and Jensen (1988), Shafranske and Malony (1990), Shafranske (1996), Crossley and Salter (2005), and Delaney et al. (2013); showed that psychologists in these international studies acknowledged that religion and spirituality should be considered in psychological treatment. These sources also showed, however, that the psychologists were unsure of how to do this in practice, primarily, because they had not received training on the interface of religion, spirituality and mental health. This had resulted in *ad hoc* practices, as discussed by Crossley and Salter (2005) that were not standardised across the profession of Psychology.

The findings in this study closely mirrored the above mentioned findings: the psychologists were able to concede that religion and spirituality should be considered, but they lacked the training, knowledge, and ethical framework within which they could effectively implement this. As shown in Chapter Five, the psychologists were also nervous of the ethical ramifications of considering religion and spirituality, because they felt that there are no clear ethical guidelines that inform this practice. However, when considering the South African context, the following points have already been established throughout this thesis:

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- The vast majority of the population of South Africa report to be followers of the Christian faith;
- The South African legislation and ethical parameters for practice specify that everyone has the right to freedom of religion, and the right to respect, human dignity, and privacy. Psychologists are required to respect these constitutional rights and are prohibited from discriminating against, demeaning, or imposing their own value systems on those whose values or beliefs differ from theirs. Psychologists are expected to be person-centred and to tailor their approach to therapy based on the preferences and needs of the client/patient;
- South African research studies point towards the necessity of integrating religious and spiritual considerations in health care domains;
- The South African context requires professionals to consider inherently spiritual and/or religious aspects of cultural and African understandings of health and illness. This context demands that health professionals be adaptable across cultural, religious and spiritual diversities (Janse van Rensburg, 2014, p. 136);
- International guidelines for integrating spirituality and religion into healthcare provide resources and evidence-based interventions or tools that could be applicable to the South African context;
- The psychologists in this study were unanimous in their agreement that spirituality and religion should be considered in the assessment, diagnosis and treatment of clients/patients;
- The psychologists in this study were similarly unanimous in their concern that there is a lack of training and education in Psychology curricula that would facilitate this integration, for example, few universities train students in the biopsychosocial-spiritual model of healthcare; and
- Furthermore, the psychologists were united in their apprehension to allow for an interface of religion, spirituality and mental health, due to the absence of an ethical framework in which to do so.

The points mentioned above provide a comprehensive, research-informed justification for religion and spirituality to be ethically integrated into the assessment, diagnosis and treatment of South African clients/patients. Although there are currently no published guidelines for this integration specific to the field of Psychology, there are numerous internationally developed guidelines that could be evaluated to establish their

suitability for the South African context. This was outside the scope of my study, but should be addressed in future research flowing from these findings. As mentioned, research within various domains of healthcare in South Africa is currently underway, and should provide suggested guidelines for ethical integration of religion and spirituality. In the interim, however, South African psychiatrist, Janse van Rensburg (2014), has published ethical guidelines for the profession of Psychiatry, which could most certainly be applied to the field of Psychology. Puchalski 's (2014) FICA tool (Chapter One, Section Three) also provides a series of appropriate and culturally-sensitive questions that professionals can use to determine the client/patient's preferences for the integration of religious/spiritual aspects into their treatment. The biopsychosocial-spiritual model (Sulmasy, 2006) is one that can be comfortably applied to the South African context and would provide both students and professionals with a framework in which to provide whole-person care.

The Health Professions Council of South Africa, specifically the Board for Psychology, should be cognisant of the lack of defined ethical boundaries for the consideration of a client/patient's religious and spiritual preferences, which often leads to haphazardly improvised practices which may, at times, be unethical. This professional board should urgently respond to this requirement for an ethical framework through continuous revision of assessment tools and procedures which align practices within the profession to current developments in research. These current developments in research include an analysis and determination of ethical principles that ought to be adhered to in the domain of religion, spirituality, culture, and psychology, with the implications thereof for the assessment, diagnosis and treatment of clients/patients.

**2. A comprehensive and culturally-inclusive definition of religion and spirituality for the South African context:** As discussed in Chapter One, the definitions for religion and spirituality are prolific and lacking in consistency (De Jager Meezenbroek et al., 2012). The data from this study further showed that the term "religiosity" lacks uniformity in both definition and in the valence that is associated with that definition. With this inconsistency comes the possibility that misconceptions and misperceptions are exacerbated, thus efficacious communication about religion, spirituality and religiosity is impeded.

Within the South African context, religion and spirituality must include reference to the multiculturalism that is inherent to this country. In Chapter One, Section Two, various definitions were provided for spirituality, religion, spiritual experience, religious experience and religious spiritual experience. A repetition of these definitions here would be redundant, but the indispensability of a unified and standardised definition for these terms within the South African context has been proven both in the findings of this study and in the research cited throughout each chapter. A standardised definition applicable to the South African context would have to include reference to multiculturalism, pluralism, the Ubuntu concept, an African worldview, and culture. It would also refer to legislative considerations discussed in Chapter One, Section Five, which include citizens' constitutional rights in these domains. The formulation of a suggested definition is outside the scope of this study (see however the next paragraph, as a step *en route*), but should most certainly be considered as a future direction for research.

**3. A position statement for the field of Psychology in South Africa that delineates a standardised standpoint on the interface of religion, spirituality and mental health:** Considering the above discussions of the prerequisites of developing an ethical code for professional psychological practice, and the standardisation of the definitions for religion, spirituality and religiosity, I want to propose the formulation of a position statement on the interface of religion, spirituality and psychological practice in South Africa. As a parallel, previously mentioned in Chapter One, the South African Society of Psychiatry (SASOP)'s position statement for the practice of Psychiatry in South Africa (Janse van Rensburg, 2014, p. 134) states the following:

SASOP position statement 9 on Culture, Mental Health and Psychiatry

Culture, religion and spirituality should be considered in the current approach to the local practice and training of specialist psychiatrists. This should, however, be performed within the professional and ethical scope of the discipline, and all faith traditions and belief systems in the heterogeneous SA society should be respected and regarded equally. In the public sector domain, no preference for one particular tradition should be given over another, as a result of a practitioner or a dominant group being from the one tradition or the other. Building relationships of mutual trust and understanding will require

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training and health education initiatives aimed at psychiatric practitioners, their patients, carers and students, and cultural and religious practitioners whom patients and their carers may choose to consult. The protection of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, however, needs to be ensured, and all forms of abuse in this context, or neglect and delay with regard to appropriate psychiatric care should be identified and prevented.

I will next formulate a proposed position statement for the practice of Psychology in South Africa, with reference to the findings of this study and other sources that will be listed in the table below. The above cited position statement published by Janse van Rensburg (2014) for the practice of Psychiatry in South Africa was used as a template for the suggested Position Statement for Psychology. I determined the following principles as being integral to a proposed position statement:

*Table 36*  
*Principles Integral to the Formulation of a Proposed Position Statement for the Field of Psychology*

<b>Principle</b>	<b>Source and/or Page Number of Source</b>
1. Interface of culture, religion, spirituality and mental health must be considered.	- Shown in the findings of this study. - Janse van Rensburg (2014).
2. Cultural Competency should be included as a basic competency for mental health practitioners.	- Shown in the findings of this study. - Research cited in Chapters One, Three, and Six.
3. Attitude of respect and tolerance for diversity and multiculturalism must be upheld by mental health care professionals.	- Shown in the findings of this study. - Constitution of South Africa and Bill of Rights. - HPCSA code of ethical practice - Mental Health Care Act 17 of 2002.
4. Freedom of religion and belief. 5. Freedom from discrimination	- South African Constitution and Bill of Rights.

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<p>applicable to mental health users and mental health professionals.</p>	<ul style="list-style-type: none"> <li>- HPCSA code of ethics, booklet 12.</li> <li>- South African Charter of Religious Rights and Freedoms.</li> <li>- The equal application of these rights to mental healthcare users and mental healthcare professionals is informed by the findings of this study that refer to intradisciplinary dynamics (Chapters Four, Five, and Six).</li> </ul>
<p>6. Human right to bodily and psychological integrity.</p>	<ul style="list-style-type: none"> <li>- HPCSA code of ethics, booklet 12.</li> </ul>
<p>7. A mental health care user has the right to be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to their full potential and to facilitate integration into community life.</p>	<ul style="list-style-type: none"> <li>- Mental Health Care Act 17 of 2002.</li> </ul>
<p>8. Relationships of collaboration and open-mindedness have to be built between mental health care professionals and religious practitioners.</p>	<ul style="list-style-type: none"> <li>- Shown in the findings of this study.</li> <li>- Supported by research in Chapters One and Chapter Six.</li> <li>- Supported by SASOP position statement (Janse van Rensburg, 2014).</li> </ul>
<p>9. Ethical Astuteness.</p>	<ul style="list-style-type: none"> <li>- Shown in the findings of this study.</li> <li>- HPCSA code of ethics and the scope of practice.</li> <li>- Supported by SASOP position statement (Janse van Rensburg, 2014).</li> </ul>

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<p>10. Training and education must be provided across the disciplines of religion, spirituality and mental health, to the end of providing whole-person care.</p>	<ul style="list-style-type: none"> <li>- Shown in the findings of this study.</li> <li>- Supported by research cited in Chapters One, Three, Four, Five, and Six.</li> <li>- Supported by SASOP position statement (Janse van Rensburg, 2014).</li> </ul>
<p>11. Tertiary institution curricula must teach the ability to deal with change and diversity, and to tolerate different views and ideas.</p>	<ul style="list-style-type: none"> <li>- White Paper on Higher Education.</li> <li>- Supported by research cited in Chapters One and Three.</li> </ul>
<p>12. Mental health care users must be protected within their religious or faith-based systems and must not be denied care.</p>	<ul style="list-style-type: none"> <li>- Informed by the ending statement of SASOP position statement (Janse van Rensburg, 2014).</li> <li>- Shown in the findings of this study.</li> </ul>

With these principles in place, I propose the following *Position Statement for the Practice of Psychology in South Africa*:

Table 37

*Proposed Position Statement for the Consideration of Religion and Spirituality in the Practice of Psychology*

**Proposed Position Statement for the Consideration of Religion and Spirituality in the Practice of Psychology in South Africa**

*The interface of culture, religion, spirituality and mental health should be considered and included in the training and practice of mental health professionals in South Africa. The constitutional rights of mental healthcare users and mental healthcare professionals must be protected at all times, to ensure their right to freedom of religion or belief and their preservation from any form of discrimination. An attitude of respect and tolerance within the context of a multicultural and diverse society should be permanently upheld by mental health professionals, and must be at the forefront of mental health interventions. The psychological integrity of mental healthcare users and mental health professionals should be ensured, and mental healthcare users must be provided with care and treatment that develops their potential and their integration into community life. Relationships of open-mindedness and collaboration should be built between mental healthcare professionals and religious/spiritual practitioners, so that mental healthcare users are free to consult with professionals or practitioners of their choosing. Ethical astuteness remains the foundation upon which mental health professionals and religious/spiritual practitioners must practice, and therefore the development of ethical guidelines to ensure this ethical astuteness is imperative, both within and between disciplines. In order to foster ethical astuteness and collaborative relationships, training must be provided across the disciplines of religion, spirituality and mental health. The sharing and co-creation of knowledge across these disciplines is encouraged in order to provide mental healthcare users with whole-person care. Furthermore, training and education should include core competencies that enable mental healthcare professionals to demonstrate ethical cultural competency in mental health practice. The protection of mental healthcare users within traditional and other religious/spiritual systems remains imperative, and*

*appropriate general health and mental healthcare must be provided to mental healthcare users without exception or delay.*

I posit that this proposed position statement could provide mental healthcare professionals with a road map *en route* to ethically grounded and unified principles by which to approach their clients/patients. Furthermore, these principles are potentially transferable into a “code of conduct” for interacting with professionals across intra and interdisciplinary boundaries.

**4. A recognition of and commitment to ethical collaboration with religious and spiritual professionals in a shared common goal for the holistic wellness of people:**

From the responses of the psychologists and the pastors in this study it is clear that there is a mutual and prevailing eagerness for collaboration between the disciplines. For collaboration to be effective, however, professionals must both recognise the benefit thereof and commit to the process of building collaborative relationships. The attitudes of professionals towards collaboration will be addressed in Discussion 2 of this section, but for the purposes of this point, the focus will be on the shared common goal of bringing about the holistic wellness of people.

If the biopsychosocial-spiritual model of healthcare (Sulmasy, 2006) is to operate in an optimal manner, then the intradisciplinary and interdisciplinary implications of this model should be defined. On this type of collaboration in relation to the biopsychosocial-spiritual model, Janse van Rensburg, Poggenpoel, Szabo, and Myburgh (2014) discuss collaborating with and referral between psychiatrists and religious or spiritual leaders. Van Rensburg et al. (2014) emphasise the fact that an understanding of a patient’s religious and spiritual background is an essential component of formulating an anthropological perspective of a patient’s health. This understanding of a patient forms the foundation upon which a cultural context can be considered when assessing the nature of presenting symptoms. Therefore, Janse van Rensburg et al. (2014) conducted a study to determine the experiences and views of psychiatrists on the role of spirituality in specialist Psychiatry practice and training, where the data of that study gave rise to the category of “referral and collaboration between psychiatrists and spiritual professionals” (Janse van Rensburg et al., 2014, p. 42). Within this category, three subcategories were identified, namely:

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1. Facilitating appropriate referral and intervention for individual users;
2. Information sharing and mutual awareness between disciplines; and
3. Addressing stigmatisation of users with psychiatric conditions.

When it comes to facilitating appropriate referral and intervention for individual users, the participants in the study by Janse van Rensburg et al. (2014) mentioned that it would be troublesome to facilitate the presence of a spiritual or religious worker within a multidisciplinary team, due to these workers not being registered health professionals in South Africa (with the HPCSA). Secondly, Spirituality is a diverse field, and therefore difficult to reduce to a singular type of spirituality. This may make it a complicated position to fill on a multidisciplinary team due to the plurality of religious and spiritual needs patients may present with. Referral to the specific spiritual leader required for a patient was therefore determined as a more plausible solution for intervention, and the continuation of collaborative efforts between psychiatrists and spiritual workers (Janse van Rensburg et al., 2014).

Psychologists are registered with the HPCSA and therefore they often form part of multidisciplinary teams (MDTs) alongside, for instance, psychiatrists. Although the religious and spiritual workers are not usually part of the MDTs, I would posit that the client/patient could request and give consent for their preferred religious/spiritual worker to be part of MDT discussions regarding their care. Members of the MDT could be mindful of the preferences expressed by clients/patients regarding religious/spiritual leader involvement by gaining their consent to collaborate and communicate with these leaders.

Information sharing and mutual awareness between the disciplines of Psychiatry and Spirituality was seen by Janse van Rensburg et al. (2014) as allowing for more communication, which could lead to information sharing. This communication and information sharing would further address any misconceptions held by either side. Greater levels of acknowledgement and acceptance can be reached through this channel of improving working relationships.

This is not only true of the discipline of Psychiatry, but could be expanded to all members of the MDTs. It is noteworthy that Janse van Rensburg et al. (2014) make reference to an attitude of acceptance and acknowledgement between professionals from the various disciplines. This is evidence, therefore, of what Discussion 2 will consider: that effective collaboration requires action (communication), and attitude (acceptance and acknowledgement).

Lastly, the findings in the study by Janse van Rensburg et al. (2014) indicate that an ambivalence still exists amongst psychiatrists about how to interact and collaborate with spiritual workers about patient care. This is most likely due to past experiences that the psychiatrists have had, and the perceptions that they therefore carry. However, these perceptions and past experiences do not negate that there is inherent value to facilitating spiritual care for patients, without becoming dogmatic about what the patient should or should not believe. Further collaboration with spiritual workers may also facilitate the reduction of stigmatisation and the assurance that patients are not on the receiving end of unsafe practices. The authors (Janse van Rensburg et al., 2014) suggest official dialoguing between professional bodies, for example, SASOP, and representatives of bodies for religious and spiritual workers, so that standards of care and referral systems can be discussed.

The ambivalence, experiences and stigmatisations reported above are not dissimilar to the ambivalence reported by the psychologists and pastors in this study, as discussed in Section D of this chapter, “the unnamed conflict of the two worlds”. Furthermore, the necessity for dialogue to occur between psychologists and pastors, so that standards of care and referral systems can be co-constructed, has now been established. As one psychologist participant stated in his interview, there has to be a process of “*demystification*” (Theme Three, Chapter Five) between the two worlds, as well as a “*co-creation of ideas*” (Theme Three, Chapter Five)

**5. Continued research on this subject matter in order to generate data that is specific to the South African context:** The only way to generate evidence-based research that is applicable to the South African context is through conducting such research. As one of the psychologist participants stated, it appears as if the subjects of religion, spirituality and mental health are not at the foreground of research that is widely encouraged, or easily funded. If religion, spirituality, culture and healthcare are going to be seriously considered in the well-being of client and patients, then research agendas will have to be aligned accordingly. Tertiary institutions will have to provide the necessary supervision and resources within these domains for the students who choose to conduct research. This study for instance gives rise to a myriad of potential research foci for South African applicability, such as:

- What are the perceptions of religious practitioners and psychologists towards the interface of religion, spirituality and mental health if the sample group used is larger and varies in selection criteria to this study?
- Is Spiritual Intelligence a concept that is understood, taught, and applied within the field of Psychology in South Africa?
- What are the religious and spiritual affiliations of South African psychologists, and how do these translate into professional practice?
- What is a context-appropriate definition for religion and spirituality in South Africa?
- How are the fields of Psychology, Pastoral Counselling and Pastoral Care differentiated in whole-person care?
- What are the experiences and expectations of clients/patients on the facilitation of their religious and spiritual beliefs within healthcare sectors?

Research can span over a number of disciplines, which is why collaborative research studies should be advanced. Many of the dilemmas found in the course of this study could be clarified through ongoing research.

**6. Formalised curricula for undergraduate and postgraduate psychological training that incorporate the above-mentioned points:** When reviewing the sources cited in Chapter One, the commonality shown between international and national studies was the scarcity and insufficiency in the education of healthcare professionals regarding the interface of religion, spirituality and healthcare. This was confirmed by the psychologists and pastors interviewed, where it was determined that the only professionals (bar one) who had received such formal training, were those who had studied internationally. One of the central reasons why this training is imperative, is because it is a perilous practice to determine the valence of aspects of religion and spirituality without having any theoretical knowledge with which to evaluate that valence. Furthermore, in order to diminish the presence of religiosity gaps, healthcare professionals should at least have a basic knowledge of the foundational tenets of a specific religion or faith tradition. Lastly, the ethical nuances of navigating between religion, spirituality, culture and mental health is a process that requires careful steering. Such skills cannot be gained through improvising as needed; these are skills that must be taught within the curricula of healthcare domains.

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In both the fields of Psychiatry and Psychology, the scope of practice includes the comprehensive diagnosis and management of psychiatric and psychological disorders, using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). Janse van Rensburg (2014b) discusses how within the DSM-V, provision is made for the consideration of cultural factors that may influence a patient, with guidelines provided for culturally sensitive formulations of diagnoses. The DSM Cultural Formulation Interview includes four main areas of assessment that pertain to cultural definitions of the presenting problem, cultural perceptions of the presenting problem, cultural factors that influence the patient's self-coping and previous patterns of help-seeking, and the cultural factors that affect the patient's current seeking of help. Furthermore, the DSM-V allows for the diagnosis of a V-code when the focus of the patient's presentation and clinical diagnosis is centred on religion and spirituality. If the scope of practice for Psychiatry and Psychology both include competent and comprehensive DSM-V diagnoses, then this is a core competency and skill that must be imparted to mental health professionals. The implication for professional practice would clearly encompass culturally sensitive diagnoses and treatment protocols, in order to ensure cultural competency. Curricula for health care practitioners in South Africa should, therefore, include the interface of religion, spirituality, culture and health.

As Puchalski et al. (2014) proposed, and was included in Chapter One, curricula should achieve this through the following five competencies:

1. Patient care: Integrate spirituality into routine clinical practice;
2. Knowledge: Acquire the foundational knowledge necessary to integrate spirituality into patient care;
3. Compassionate presence: Establish compassionate presence and action with patients, families, and colleagues;
4. Personal and professional development: Incorporate spirituality in professional and personal development; and
5. Communications: Communicate with patients, families, and healthcare teams about spiritual issues.

These competencies can be applied to the South African context with ease, including the assessable pedagogic outcomes of the second competency, knowledge, for which Puchalski et al. (2014) suggest that students select, study and present about three to four different religions or faith traditions. This would work well within South African curricula, because it would allow

students to engage with the multiculturalism of the country, and would give opportunity for the students to learn from one another.

### **Discussion Two: The Modus Vivendi for collaboration between the world of the pastors and the world of the psychologists**

In order for psychologists and pastors in South Africa to consider the ethical interface of religion, spirituality and mental health, there must be a shared commitment to collaboration, so that the distance between the “two worlds” can be lessened. This collaboration would require a willingness for professionals to refer to one another, and would entail a few other mandatory processes, which will be reviewed in this discussion.

Janse van Rensburg et al. (2014) state that a framework should be created within the discipline of Psychiatry for referral to and collaboration with spirituality. As previously mentioned, a framework such as this is similarly lacking in the field of Psychology in South Africa and would be valuable to the profession. For this reason, the framework discussed by Janse van Rensburg et al. (2014, p. 44) will be utilised below with the intent of drawing a parallel to what is required in the field of Psychology:

#### Proposed Framework For Collaboration and Referral:

**1. Clarifying agendas and confirming definitions:** The pastors and psychologists both inadvertently or directly reflected on the fact that they would require transparency in the communication between the two disciplines. They further mentioned that if the care that is given to people is based on a holistic, whole-patient care model, then the term “whole-person” has to be clarified for both professions. The biopsychosocial-spiritual model makes provision for the spiritual dimension to be incorporated, but the agendas of professionals who treat those dimensions should be aligned in order for the person to receive effective and ethical treatment. These are not the only agendas that ought to be clarified. As mentioned, the pastors verbalised their prerequisite for referral to be preceded by knowledge of the values to which the mental health professional subscribes.

By implication, knowing the values of the professional to whom a referral will be made, will provide the pastor with an indication of the professional’s agenda for treatment. The psychologists in the sample studied voiced concern about lay counsellors, and sometimes pastors, who counsel congregants about clinical disorders without having the necessary training to do so. The psychologists, therefore, expressed a desire to

communicate with pastors more openly so that they can determine whether or not they will have the support of the pastor during the treating of a congregant. Therefore, it seems as if both the pastors and psychologists would benefit from a confirmation of one another's agendas.

**2. Terminology and scope of practice:** The disparity in how the terms of religion and spirituality are defined is one that has been reviewed at length throughout this thesis. As stated by Janse van Rensburg (2014), therefore, it is imperative for these terms to be uniformly defined so that communication can proceed unhindered.

Linked to the defining of terminology comes the equally important definition of scope of practice. As mentioned, the biopsychosocial-spiritual model provides a framework for whole-person care, but it does not specify the particular roles that are filled within that framework; certainly not for a South African context. The scope of practice should be reviewed so that there is a clear distinction of the boundaries of each profession, as well as how their spheres may overlap. This can only be addressed by dialoguing between the professions in a non-confrontational manner, which is one of the findings that was stated from the pastors' and psychologists' data in this study.

**3. Establishing the role of culture, religion and spirituality in different communities, and obtaining the different perspectives of particular faith traditions or belief systems on health and mental health:** With South Africa being a multicultural society, there are numerous faith traditions and cultural belief systems, all of which must be given equal standing (Coertzen, 2014). It is not possible to gain a comprehensive understanding of these traditions and systems unless they are each given due consideration.

This would best be achieved through education and training of mental health professionals in the tenets of these systems, which could be facilitated through dialogue between religious/spiritual workers and mental health professionals. This process could also be achieved by including core modules on religion and spirituality in the curricula of mental health professionals, as previously mentioned.

Research endeavours that focus on this point - establishing the role of culture, religion and spirituality in different communities, and obtaining perspectives of particular faith traditions or belief systems on health and mental health – would be a valuable contribution to our understanding. Lazarus, Seedat and Naidoo (2009) support the generating of such research; this is evidenced by their study on mobilising religious health

assets to build safer communities. Religious health assets are defined by Lazarus et al. (2009, p. 5) as “assets that are located in or held by a religious entity that can be leveraged for the purposes of development or public health”.

The concept of “religious health assets” (Lazarus et al., 2009) is closely paralleled by the sociological concept of “spiritual capital” (Lombaard, 2015) which stems from Bourdieu’s (1986) concept of “social capital”. When reviewing the definition of Bourdieu’s (1986) concept of social capital, Gelderblom (2014, p. 3) describes social capital as “a resource in the hands of individuals in their striving to improve their absolute and relative position in society”. This resource can be extended to the inclusion of religious and spiritual capital which considers the influence that religious people can have on society, or the influence that religion can have on people in society (Gelderblom 2014; Lombaard, 2015). Although a more thorough review of the concept of social capital and spiritual capital is outside the scope of this study, the notion of spiritual capital is a potentially valuable one for the South African context and should be a focus of future research. As Lombaard (2015, p. 6) states, “the concept of spiritual capital has inherent to it the (typical post-secular – Lombaard 2014) acknowledgement that a sense of the divine amongst human agents has the potential to influence society differently, precisely because it brings about sensitivities and activities to improve the circumstances of those in dire need”. Lazarus et al. (2009), Gelderblom (2014) and Lombaard (2015) each consider the possibility of spiritual and religious beliefs being harnessed to influence society, which holds prospective value for the South African population. With this potential in mind, Lazarus et al. (2009) reviewed whether or not religious health assets could be mobilised to mediate the occurrence of interpersonal violence in South African communities that had been historically colonised, and to thereby promote peace. There were four primary questions that Lazarus et al. (2009, p. 7) posed for African contexts, namely:

- How can religious health assets be used to heal communities who have experienced oppression and structural violence?
- How can religious health assets be used to limit discourses justifying aggression at interpersonal and collective levels?
- How can peace activists connect to faith-based services for the purposes of developing compassion and solidarity, thereby preventing violence and social injustice?

- What is the role of religious health assets in addressing underlying social determinants of violence for the purposes of promoting safety and peace in Africa?

As can be deduced from the above posed questions, religious health assets may hold significant value in redressing oppression, violence and aggression, as well as promoting social justice, peace and safety within Africa. Although the methodology and findings of the Lazarus et al. (2009) study is too comprehensive to be detailed here, their findings suggest that the participants experienced the programme as being an “intensely deep emotional and spiritual engagement with the notions of positive masculinity that is empowering” (Lazarus et al., 2009, p. 15). Therefore, the benefit of research that considers the role of religious health assets within the South African and African contexts must inform further research agendas.

**4. Providing information on evidence-based management of serious psychiatric conditions (risk factors, symptoms, diagnoses, treatment) to spiritual advisors/ workers and to patients:** The above suggestion interacts closely with Chapter Four, where the explanation of the pastor’s existential experience of the “two worlds” was described. One of the primary contributors to this experience was that the pastor felt as if the “world” of psychology, psychiatry and mental health was entirely foreign to his own.

This was attributed to his lack of training, education and knowledge in the mental health fields, which had resulted in him having far more “questions” than “answers”. The pastors (bar one pastor) reflected on their inherent need to gain an understanding of the “world” of mental health. Not only would this result in a perceived lessening of the distance between the “worlds”, but it would also equip the pastors with essential information on when to refer congregants for professional help; and what the boundaries of each discipline are. If the pastors had this knowledge, it would decrease the number of times that congregants received clinical care from unqualified sources. The psychologists in this study commented on the cross-pollination of knowledge by expressing their willingness to provide such training to pastors, but wanted this process to be a reciprocal one too, so that their proficiency in understanding various faith traditions could be reinforced.

**5. Taking measures to ensure compliance, destigmatisation and optimal outcomes of psychiatric treatment:** A process of destigmatisation is one of the primary findings from the data from this study, as discussed in Chapters Four, Five, and Six. The

stigmatisation of both mental health and religion and spirituality was documented throughout this thesis, as the bedrock upon which much of the “unnamed conflict” had been formed.

Stigmatisation occurs from direct and vicarious experiences, which would imply that both direct and vicarious experiences can shift stigmatisations. This was evidenced first-hand in the process of my data collection; the pastors’ perceptions shifted considerably during the interviews, to the point that some of them recanted statements made in the beginning stages of the interviews. The psychologists similarly exhibited a shift in how they perceived the interface of religion, spirituality and mental health by virtue of the questions which were asked. One psychologist said the following to me as we walked out of the interview room:

*This was an interesting interview ... you made me think ... some of your questions were ones that I had predicted you would ask ... but some of them were not...*

The research participants’ perceptions were modified through their experience of being interviewed, but my own perceptions were just as powerfully transformed through this same process. This indicated to me that dialogue, social constructivism of knowledge, and new experience results in altered perceptions, and the redressing of stigmatisations.

Therefore, one of the primary means of achieving this destigmatisation would be through collaborative dialogues to be fostered between disciplines. Not only would this improve the provision of whole-person, but it would give the pastors an opportunity to evaluate the progress of congregants receiving mental health care, so that the outcomes of that treatment can be facilitated. In this way, the pastor and the mental health practitioner would be working towards a similar agenda.

All of the suggested frameworks by Janse van Rensburg et al. (2014) can be paralleled with the findings shown in this study. Janse van Rensburg et al.’s (2014) model for collaboration and referral has been demonstrated above to be a useful adjunct to the suggestions that I have already stipulated. The final diagram presented in Chapter Six will incorporate these principles.

Edwards, Lim, McMinn, and Dominguez (1999) have similarly published suggestions for collaboration and referral between mental health professionals and clergy. The context

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thereof is different in the USA, because clergy are frequently incorporated in MDTs and even within some hospital or clinic settings, because they have received training that equips them to work in such settings. Nonetheless, the principles posited by Edwards et al. (1999) provide research that corroborates the above-mentioned points, including the following:

- Mutual Consultation: Both psychologists and clergy reported a sense of appreciation for times when a professional from either discipline had consulted one another on salient issues. This mutual consultation was linked to a reciprocal valuing of one another. At times, this collaboration entailed clergy and psychologists joining forces and presenting workshops or seminars alongside one another – with positive results;
- Academic Collaboration: Professionals frequently collaborated academically by presenting lectures together, or by asking professionals across disciplines to teach specific subjects for example, psychologists lecturing seminary students about mental health; and
- Referrals: Although it was more frequently the case that clergy referred to psychologists rather than psychologists to clergy, representatives of both disciplines were able to recount instances when referral across disciplines had led to substantial gains for the client/patient. This encouraged professionals to investigate continued opportunities for such cross referral.

Edwards (1999) further listed obstacles to collaboration:

- There is a lack of awareness from psychologists about the significance of client/patient's religious and spiritual beliefs, as well as psychologists' lack of time for collaborating across disciplines;
- Professional concerns, such as the approach to confidentiality, impede their willingness to collaborate, out of fear that the information given to other professionals would be misused; and
- Clergy do not always charge a fee for their services, some of these services are provided by clergy on a volunteer basis, while psychologists more regularly charge a fee, although they do at times volunteer their time too. This can diminish the potential for collaboration, because psychologists may not be able to work on a pro-bono basis.

Of all the obstacles listed by Edwards et al. (1999), the obstacle of interdisciplinary disdain is the one most frequently communicated between the two disciplines. Some of the findings from Edward's (1999) study can be paralleled with the findings of this study. To illustrate this, Edward's (1999) findings will be correlated with the findings of this study in the points below:

1. Some clergy resisted collaboration, because they interpreted psychological interventions as being in competition with spiritual ones, as illustrated by the following two quotes in Edwards (1999, p. 550):

“God offers hope. What does the psychologist offer?” and

“Why would someone seek advice from someone too dumb to accept salvation?”

- Both of these quotes reflect some of the pastors' fears and concerns recorded in this study, as discussed in Theme One of Chapter Four.

2. Some psychologists (Edwards, 1999) had become disillusioned with interventions offered by clergy, because they perceived them as being promoted as a “panacea for all psychological distress”.

- As mentioned in the point above, this obstacle to collaboration was similarly represented in this study, indicating that psychologists saw the pastoral role as encouraging a reductionist perspective on psychological distress (Theme One, Chapter Five).

Not only did Edwards (1999) consider a model for interdisciplinary cooperation, but Budd (1999) similarly published a United States of America Air Force model for psychologist-chaplain collaboration that reflects many of the principles discussed in Edwards et al.'s (1999) model. Budd (1999) succinctly states that, within the military setting, collaboration is essential, because the “safety net for resolution of more complex psychiatric disorders frequently falls on the shoulders of the offices of mental health therapy providers and the clergy, operating conjointly to synergistically provide optimal healing services” (Budd, 1999, p. 555).

The above discussions indicate that collaboration is necessary to ensure optimal mental health care, but that it is also possible for collaborative relationships of mutual respect and recognition to be fostered. In Greyvensteyn (2018), based on the pilot study results of this study, I postulated that the following three factors would have to be in place for integration of the disciplines to be fruitful:

1. Open-mindedness (within and across disciplines) versus closed-mindedness (within and across disciplines);
2. Knowledge astuteness (within and across disciplines) versus knowledge complacency (within and across disciplines); and
3. Collaboration (within and across disciplines) versus fragmentation (within and across disciplines).

These principles are ones that have already been referred to in the findings chapters (Chapters Four and Five). Open-mindedness would most certainly be beneficial not only for collaboration, but equally so for the redress of stigmatisation. Knowledge astuteness is required within both the disciplines of Psychology and Pastoral Ministry; it is similarly required between the two fields. The over-arching conclusion stemming from the main study findings is that both the pastors and the psychologists had a desire for collaboration. Therefore, the *modus vivendi* would be one of collaboration.

When comparing this finding to the pilot study findings, it becomes apparent that the two sets of findings differ in one fundamental way:

- The pilot study provided an indication that an integration of religion, spirituality and mental health should *include* open-mindedness, knowledge astuteness and collaboration.
- The main study data supported the pilot study findings, but expanded on those findings by demonstrating that this integration of religion, spirituality and mental health should be *achieved through* a process of collaboration.

Therefore, these main study findings indicate that the integration of religion, spirituality and mental health would best be facilitated through a process of collaboration. The question that has arisen from the main study data is **how** that collaboration should be facilitated.

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In order to answer the question of how collaboration, to the end of integration, should take place, I am in essence asking how the “unnamed conflict” between (and within) the “two worlds” can be navigated, so that collaboration can be successful. By asking this question within the context of the “unnamed conflict” and the “two worlds”, it is crucial to consider the world of the pastor and the world of the psychologist as illustrated in Figure 7 and Figure 8. It is also useful to consider the elements that are encapsulated by the “unnamed conflict”, so that it can be effectively named, as shown in Section D. The illustration, therefore, of a model of collaboration ought to be preceded by an illustration of the “unnamed conflict”, as in Figure 9. Once these components can be named and identified, the suggested solution to those components can be posited. The solutions posited would then be integral to valuable collaboration. Reflecting on Table 34 to refresh the memory, the “unnamed conflict” is characterised by the following components:

*Table 34*  
*Factors Forming and Characterising the Unnamed Conflict*

<b>The Unnamed Conflict</b>	
<b>Formed Through</b>	<b>Characterised By</b>
Perceptions	Disconnection
Stigmatisations	Prejudice
Ethical Negligence	Arrogance Ignorance
Lack of Knowledge	Divided <i>Weltanschauung</i>
Lack of Training	Nervousness
Experiences	Mistrustfulness
Antipathy	Antipathy

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In effect, the table above outlines the obstacles to integration and collaboration, both within and between disciplines. For the sake of collaboration, the obstacles must be countered with “bridges” between the two worlds. As one of the pastors mentioned:

*I feel as if we are between worlds now. And we've got bridges and there's links, and we're kind of crisscrossing on ropes, but we're crisscrossing with trepidation and with, you know, a sense of almost... There are bridges linking those **two worlds** but they are still tentative bridges, I feel we're out of our depth, because we're between worlds.*

*And so.. because we're in **two worlds**, I don't, we don't speak about it.*

*So it's a big world and I think we're out of our depth, but it would be good to bring the two together\_with ..... so now no longer just the bridge and the thin threads, but with a sort of trapeze dance between the two to begin to emerge.*

This pastor emphasises that the distance between the two worlds has to be lessened through “bridges”, because although some bridges already exist, the bridges are ones that contain thin threads, instead of being robust bridges that can provide security and stability for those crossing between the worlds. To address the urgency for the provision of such bridges, I will postulate a suggested “bridge” to counter each “obstacle” in the following table; many of the bridges will correspond to the research included in Chapters One and Six:

Table 38

*Modus Vivendi of Building Bridges in the Unnamed Conflict of the Two Worlds*

<b>Modus Vivendi of Building Bridges in the Unnamed Conflict of the Two World</b>	
<b>Obstacle</b>	<b>Proposed Bridge</b>
Perceptions	Formation of New Perceptions
Experiences	Openness to New Experiences
Stigmatisations	Redress of Stigmatisations through Communication and Restoration
Ethical Negligence	Ethical Astuteness
Lack of Knowledge	Acquisition of Knowledge
Lack of Training	Mandatory Integrated Training and Cultural Competency

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Disconnection	Connection
Prejudice	Tolerance
Divided Weltanschauung	Integrated Weltanschauung
Nervousness	Courage
Mistrustfulness	Trustworthiness
Antipathy	Empathy

These proposed bridges would provide an opportunity for the unnamed conflict of the two worlds to begin a process of gradual metamorphosis. However, the bridges themselves entail **actions**, processes that have to be put in place. Bridges and actions are useful, but they have to be constructed within the parameters of specific **attitudes** that would form the relational framework for collaboration. **Actions without corresponding attitudes** would circumvent and undermine collaborative attempts. There would be no value in open communication if that communication was laced with contempt or disdain. Therefore, for each bridge, each **action**, to be advantageous and fruitful, the following **attitudes** must coexist alongside the bridges:

*Table 39*  
*Proposed Action and Attitudes for the Modus Vivendi*

<b>Proposed Action and Attitudes for the Modus Vivendi</b>	
<b>Proposed Bridge (Action)</b>	<b>Accompanying Attitude</b>
Formation of New Perceptions	Willingness
Openness to New Experiences	Open-mindedness
Redress of Stigmatisations through Communication and Restoration	Humility Honesty Compassion Diplomacy Acceptance
Ethical Astuteness	Open-mindedness Integrity Teachableness

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Acquisition of Knowledge	Teachableness Open-mindedness Humility
Mandatory Integrated Training and Cultural Competency	Commitment Open-mindedness Willingness
Connection	Respect Acknowledgement Humility
Tolerance	Forbearance Humility Transparency
Integrated <i>Weltanschauung</i>	Flexibility Perseverance Open-mindedness
Courage	Courage
Trustworthiness	Integrity
Empathy	Appreciation Understanding

If these attitudes are in place within the bridges that are formed, then both intradisciplinary and interdisciplinary integration can be cultivated.

Considering that the findings in this study demonstrate a lack of integration of religion, spirituality and mental health within and between disciplines, it seems fitting to postulate that a model of Integrated Collaboration is imperative. To this end, I propose the term “Integrated Collaboration” as the findings of the pilot study and the main study demonstrate that integration is required within disciplines, and that collaboration is required both within and between disciplines. Therefore, the collaboration itself must be integrated, in order to be efficacious. I would also postulate that this model would not only be applicable to the disciplines of Psychology and Pastoral Ministry, but would be relevant to other disciplines and professionals that may want to collaborate within or across disciplines for example, psychiatrists, social

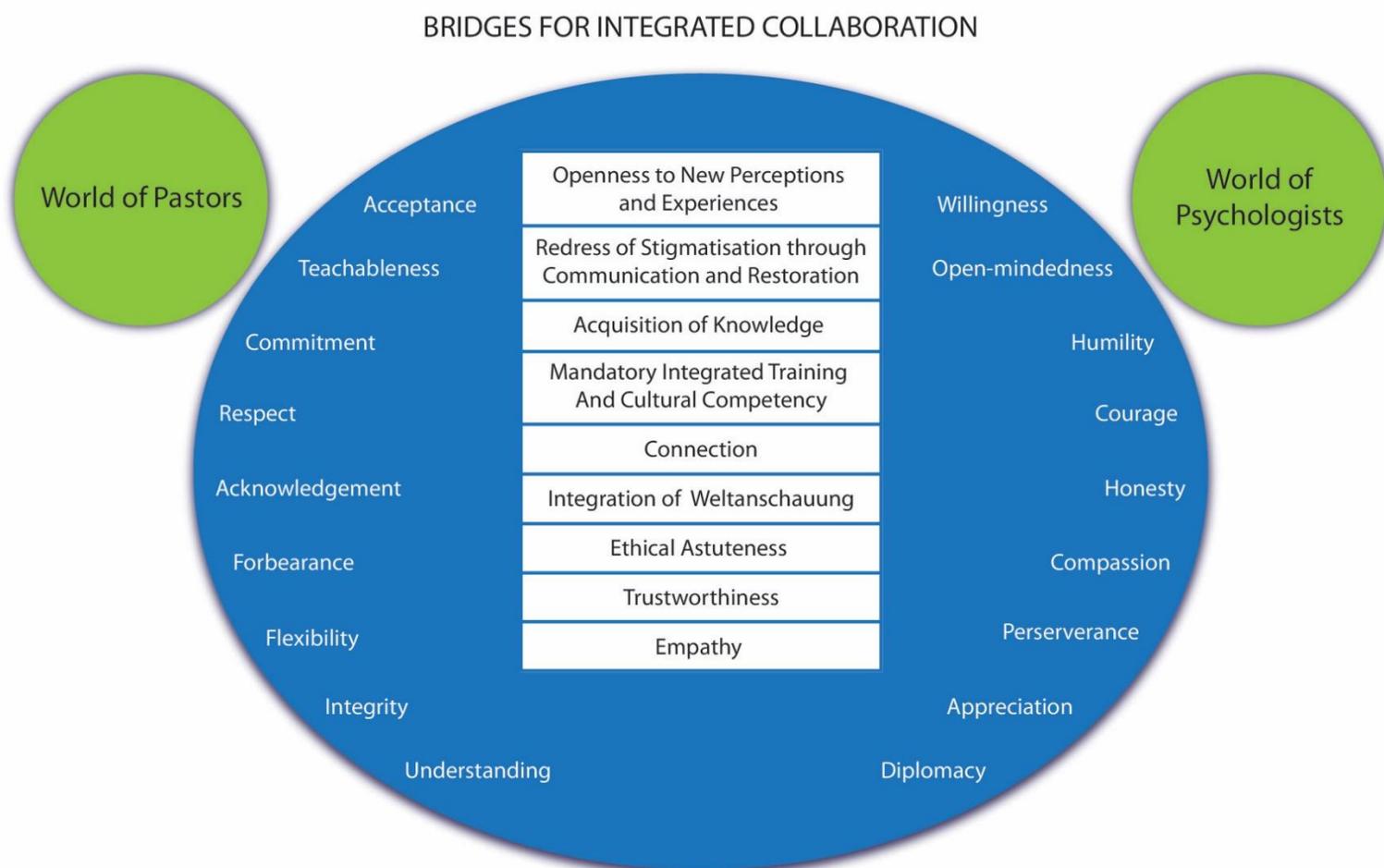
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workers, speech therapists, medical doctors, registered counsellors, pastoral counsellors, and lay counsellors.

In concluding this section, I propose the following statement:

There are obstacles to the **Modus Vivendi of Integrated Collaboration** between, and within the fields of religion, spirituality and mental health. However, these obstacles can be minimised through attitudes and actions that are conducive to building bridges in the unnamed conflict of the two worlds.

To represent this statement in a coherent manner, the use of a figure is fitting:



*Figure 9: Modus Vivendi Bridges for Integrated Collaboration*

Figure 9 personifies the metaphorical, allegorical language that has characterised the findings of this study. The existential realities and tensions described by the participants become palpable; it is their voices that are verbalised, but it is also their expectations and yearnings for the future that are captured. The bridges (actions) and attitudes provide a feasible *modus vivendi* for establishing integrated collaboration both between and within the disciplines of religion/spirituality and mental health.

### **Section G: Concluding Thoughts**

#### **The South African National Anthem**

##### **(Verse 1 and 2)**

**Nkosi sikelel' iAfrika (Xhosa)**

*God [Lord] bless Africa*

**Maluphakanyisw' uphondo lwayo, (Xhosa)**

*May her glory be lifted high*

**Yizwa imithandazo yethu, (Zulu)**

*Hear our petitions*

**Nkosi sikelela, thina lusapho lwayo.(Zulu)**

*God bless us, Your children*

**Morena boloka setjhaba sa heso,(Sesotho)**

*God we ask You to protect our nation*

**O fedise dintwa le matshwenyeho,(Sesotho)**

*Intervene and end all conflicts*

**O se boloke, O se boloke setjhaba sa heso,**

**Setjhaba sa, South Afrika.(Sesotho)**

*Protect us, protect our nation, our nation, South Africa.*

Through the compilation of this study, I have been reminded of my immense patriotism and compassion for the country I call home. Multiculturalism, diversity and rich cultural heritage are the foundations on which this country thrives. The beauty of our nation has been ravaged by an oppressive, prejudiced and discriminatory past, the ramifications of which still require ongoing healing and restoration. The remnants of our past are captured in some circumstances of the present, including attitudes that perpetuate bias and stigmatisation, instead of mutual respect. This was evidenced by the findings of this study that indicated intra- and

interdisciplinary tension, and recent movements within South Africa towards the decoloniality of knowledge. There has been a fracture between the “two worlds” of pastoral ministry and psychology, which has birthed an “unnamed conflict” between the two. However, there is a willingness to move towards restoration, collaboration and reciprocal acknowledgement; a *modus vivendi* is valuable in shifting us from the present into the future.

South Africa’s enchantment is found in the people that inhabit its beauty. People who have been shaped by the socio-political contours of the land, people who have wept, people who have overcome, people who have restored, people who have rejoiced, and people who hold hope. Our national anthem personifies the heartbeat of South Africa’s people. It boldly proclaims the endurance of its religious, spiritual, cultural and traditional roots by asking God to bless this nation, for God to hear the petitions of its children, for God to protect, and for God to intervene to end all conflicts.

*O fedise dintwa le matshwenyeho (intervene and end all conflicts)*... When singing this sentence, I cannot but draw a parallel to the intimacies, the tensions and the conflicts that have been reviewed in this study. Not only have we been provided with insight about the nature of this conflict, but we have also found a plausible route through it. In Chapter Two, I provided biographical information about myself, including the fact that I am a Christian; therefore, the lyrics of the anthem resound and reverberate within me. In this way, my humble interpretation of this study is of a God-guided beginning in bringing a modicum of reconciliation to the “unnamed conflict”.

In closing, I pay tribute to the former President Nelson Mandela, the man who fathered South Africa and led its liberation. It is my earnest prayer that we, as South Africans, will respond to one another with compassion, that we will find unity in our humanity, and that we will thereby personify Ubuntu.

***“Human beings regard their mental capacity as the most defining feature of themselves. To respond in a caring manner to the impairment of those capacities in others is to really know ourselves as human beings and to live out our humanness.”***

***Nelson Mandela***

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APPENDICES

Appendix A: Informed Consent

**Informed Consent Form**

I, Wendy-Leigh Greyvensteyn am conducting a study on the perceptions of church leaders and psychologists towards the integration of Christianity and psychology. This is a PhD study that is registered with the Department of Psychology at the University of South Africa (Unisa).

The purpose of this study is to determine the perceptions of church leaders and psychologists towards the integration of Christianity and psychology, so that conclusions can be drawn on this interaction. I would appreciate it greatly if you would be willing to become a part of this study.

Insights will be gained through research interviews of one to two hours in duration. With your permission, these interviews will be recorded in order for me to transcribe our conversation accurately at a later stage.

These detailed transcriptions become part of the sources of my analyses. As the study progresses, I may briefly follow up with you (via email or telephone) to clarify a matter or two.

If you agree to be a part of this study, as I sincerely hope you will, your anonymity will be protected throughout and after the study. No distinguishing information will be used that could potentially identify you as a participant. Everything that is discussed with me will be strictly confidential, and your privacy will be protected at all times throughout and after this study. When the study is reported on through its eventual publication, conference presentations and academic articles, your anonymity and confidentiality will be maintained through the use of pseudonyms.

For the interview, I intend to meet you at a place that is convenient for you. However, should you have to incur any travel costs, it will be covered by me.

Your participation in this study is entirely voluntary, and as such, you are free to withdraw your participation completely from this study at any time, should you so wish.

Your signature below confirms that you have read the above information and that you agree to these arrangements. This consent form will be signed by you and by me as the researcher, in an agreement between the two of us.

If you agree to voluntarily participate in this study, then please complete the section below:

I \_\_\_\_\_ (full name and surname) have read and understood the informed consent agreement above and agree to take part in this study in an invited, voluntary capacity.

Participant's Signature	
Date	
Researcher's Signature	
Date	

**Appendix B: Ethical Clearance Certificate**

Ref. No: PERC-16022



**Ethical Clearance for M/D students: Research on human participants**

*The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.*

**Student Name:** Wendy-Leigh Greyvensteyn **Student no.** 5853-566-7

**Supervisor:** Dr Masefako Gumani **Affiliation:** Dept. of Psychology, Unisa

**Co-Supervisor:** Prof Christo Lombaard **Affiliation:** Department of Christian Spirituality

**Title of project:**

*The perceptions of Christian church leaders as well as psychologists towards the role of Christianity in Psychology: A Grounded Theory Approach*

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department of Unisa. The application was approved by the Ethics Committee of the Department of Psychology on the understanding that –

- All ethical requirements regarding informed consent, the right to withdraw from the study, the protection of participants' privacy and confidentiality of the information should be made clear to the participants and adhered to, to the satisfaction of the supervisor;
- If further counseling is required in some cases, the participants will be referred to appropriate counseling services.

Signed:

A handwritten signature in purple ink, appearing to read 'M Papaikononou', enclosed in a purple oval.

**Prof. M Papaikononou**

Date: 2016-07-15

[For the Ethics Committee ]  
[ Department of Psychology, Unisa ]

***The proposed research may now commence with the proviso that:***

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.***
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Psychology Department Ethics Review Committee.***
- 3) An amended application should be submitted if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.***
- 4) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.***

***Please note that research where participants are drawn from Unisa staff, students or data bases requires permission from the Senate Research and Innovation Committee (SENRIC) before the research commences.***

**Appendix C: Condensed Curriculum Vitae: Wendy-Leigh Greyvensteyn**

**Name:** Wendy-Leigh

**Surname:** Greyvensteyn

**Identification Number:** 8312300211084

**HPCSA Registration Category and Number:** Clinical Psychologist, PS0106518

**Nationality:** South African (Hold dual passports for South Africa and for the United Kingdom)

**Language:** English First Language, Afrikaans Second Language

**Marital Status:** Married

**Dependents:** Three Children

**Driver's License:** Code 8

**Criminal Record:** None

**Next of Kin:** Husband, Jan Greyvensteyn 082 466 1575

**Postal Address:** P.O. Box 2110. Silverton, 0127, Pretoria.

**Contact Details:** [whurlin@hambanet.co.za](mailto:whurlin@hambanet.co.za); [wendy.greyvensteyn@gmail.com](mailto:wendy.greyvensteyn@gmail.com)

**ACADEMIC QUALIFICATIONS**

<b>Degree</b>	<b>Year of Completion</b>	<b>Institution</b>	<b>Comments</b>
PhD Candidate (Department of Psychology)	2015 - Present	University of South Africa	In process
MA: Clinical Psychology	2008	University of Pretoria	Cum Laude
Bachelor of Social Science (Honours)	2006	University of Pretoria	Cum Laude
Bachelor of Social Science	2005	University of Pretoria	Cum Laude
Matric Certification	2001	Pretoria High School for Girls	Distinctions: English First Language; Geography HG.

**EMPLOYMENT HISTORY**

<b>Position Held</b>	<b>Institution</b>	<b>Period of Time</b>
Business Owner and Co-Founder	House Inkanyezi	2002 - Present
Clinical Psychologist	Private Practice	2010 – Present
External Consulting Clinical Psychologist	Cornerstone College	2010 – Present
External Consulting Clinical Psychologist	City Capitol Church International (3ci)	2012 - Present

**ACADEMIC PRESENTATIONS**

<b>Title of Presentation</b>	<b>Conference</b>	<b>Date</b>
The Ethical Integration of Religion, Spirituality and Mental Health	PSYSSA Annual Conference (Psychological Society of South Africa) (Johanneburg)	September 2018
Two Worlds and the Unnamed Conflict	Spirituality, Theology, and Education Conference (UNISA, Pretoria)	September 2018
Pilot Study Findings: The Interface of Religion Spirituality and Mental Health within the South African Context	World Psychiatric Association Congress Conference (Cape Town)	November 2016

## THE INTERFACE OF RELIGION, SPIRITUALITY AND MENTAL HEALTH

Pilot Study Findings: The Interface of Religion Spirituality and Mental Health within the South African Context	2nd Biennial Conference for Spirituality and Health (Pretoria)	October 2016
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### ACADEMIC PUBLICATIONS

Greyvensteyn, W. L. (2017). The ethical integration of religion and spirituality in mental health within a South African context, with an emphasis on Christianity. In A. De la Porte, A. Oberholzer, and N. Joubert (Eds.), *Proceedings of 2nd Biannual South African Conference on Spirituality and Healthcare*. Newcastle upon Tyne, United Kingdom: Cambridge Scholars Publishing.

Macklin, D., Greyvensteyn, W. , Molale, M. (2008). Multiculturalism and your child. In L. Cilliers (Ed.), *Happy Years: A Guide for Parents*. Abraham Kriel Childcare: Johannesburg.

Greyvensteyn, W., & Macklin, D. (2008). The Smarty System. Published Poster at SASOP conference 2008.

### REFERENCES

Dr Annemarie Potgieter  
Psychiatrist (Colleague)  
012 362 1581

Pastor Rory Dyer  
Capital City Church International  
012 940 0346

Celia le Roux  
Vice Principal  
Cornerstone College  
012 804 8350

**Appendix D: Turnitin Report and Analysis**

- Processed on: 07-Nov-2018 17:39 SAST
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- Word Count: 124715
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[Edward P. Shafranske. "Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy.", \*Psychotherapy Theory Research Practice Training\*, 1990](#)

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[Otilia Brown. "The Use of Religion and Spirituality in Psychotherapy: Enablers and Barriers", \*Journal of Religion and Health\*, 11/11/2011](#)

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**Appendix E: Proof of Editing**

**Lindsay van Zyl Editing**

**Tel:** (012) 991 8915  
**Cell:** 082 505 0280  
**E-mail:** [lindsay.vzyl@gmail.com](mailto:lindsay.vzyl@gmail.com)

**INVOICE NR WG-2018/1-4**

**Name:** Wendy  
**Attention :** Wendy Greyvensteyn  
**E-mail:** [whurlin@hambanet.co.za](mailto:whurlin@hambanet.co.za)

**Tel:**  
**Cell:** 0826564628

**10.09.18**

Hours	Description	Rate/Hr	Total 'R'
9.5	Ch 1 PhD thesis (70 pages, 24740 words)	200	1 900
5	Ch 2 PhD thesis (50 pages, 16978 words)	200	1 000
2.5	Ch 3 PhD thesis (18 pages, 6453 words)	200	500
5.5	Ch 4 PhD thesis (66 pages, 21300 words)	200	1 100
7	Ch 5 PhD thesis (84 pages, 25187 words)	200	1 400
9	Ch 6 PhD thesis (65 pages, 21893 words)	200	1 800
38.5			
		<b>Total</b>	<b>R 7 700</b>

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