Perceptions of Black Pentecostal Pastors on Potential Collaboration with Mental Health Care Professionals: Insights from South Africa

Lesley Takalani Mauda
ORCID iD: https://orcid.org/0000-0001-5357-2414

Mpsanyana Makgahlela
ORCID iD: https://orcid.org/0000-0003-4973-5692

Abstract

The debate regarding the relevance of religion and spirituality in mental healthcare has remained vigorous overtime. Religious and psychological studies have supported the view that Mental Healthcare Professionals (MHCPs) and Pastors share the same commitment towards the alleviation of their service users' suffering. However, it is not well known as to what extent are these parties willing to collaborate their services for the mutual benefit or common good of service users. This qualitative study sought to explore and describe Black Pentecostal pastors' views regarding possible collaboration between themselves and MHCPs. A Bio-Psycho-Social-Spiritual (BPSS) framework was used to guide this study. A total of 19 participants were selected through purposive sampling and interviewed using semi-structured interviews. Data were analysed through Thematic Analysis approach (TA).

From the analysed data, three major themes emerged, and are as follows: (a) Pastors' expressed willingness to collaborate with MHCPs; (b) Pastors are willing to collaborate with MHCPs of all religious backgrounds; and (c) Pastors considered several factors before referring service users to MHCPs. Evident from the data was that some pastors had already made referrals to MHCPs while others had ongoing informal collaborations. In the main, it was found that Black Pentecostal pastors, although they held varying perceptions regarding collaboration, mostly held a positive attitude towards collaborating with MCHPs, especially those of a Christian background. The

Print ISSN 1023-1757; Electronic ISSN: 2519-5476; DOI https://doi.org/10.29086/2519-5476/2024/v31n1a3

major implications of this study are two folds; a) from Black Pentecostal pastors perspective, there's room for collaboration with MHCPs, however, the latter should also be willing to collaborate, and b) there's an urgent need for the government to guide strategy on achieving this collaboration. These are considerations which could impact positively on service users' access to holistic mental health care services in contemporary South African context.

Keywords: Black Pentecostal pastors, MHCPs, Collaboration, intervention programme

Introduction

Documented evidence underscores the relevance of Christian faith and pastors in mental health care (e.g., Koenig 2012:15; Lloyd *et al.* 2023:352). Pastors have historically been entrusted with the responsibility of addressing fellow community members' spiritual and mental needs. Regarding mental health care, there are a several studies (e.g., Dein 2017; Kumar 2018; Koenig *et al.* 2019; Luchetti *et al.* 2021) proving on the positive contribution of religion to mental health and wellbeing. Koenig and colleagues noted that religious beliefs aided in the improved recovery from depression. Luchetti *et al.* (2021:7627) maintain that despite the noted significance of religiosity in mental health by previous researchers, a gap still exists regarding pastors' formal involvement and contribution in the mental health care delivery. Specifically, pastors have been rarely viewed as partners in community mental health care (Murambidzi 2016:3). In fact, some MHCPs have argued that religion has no place in mental health (Vergese 2008:233), an attitude which perhaps could account for studies (e.g., Janse van Rensburg, *et al.* 2014:43) which tended to suggest that most medically oriented professionals are less inclined to collaborate with pastors.

Even though collaboration rarely happens between pastors and MHCPs, it is common knowledge that when individuals experience mental health challenges, they prefer to consult with their pastors first before consulting MHCPs (Jackson 2017:18). For pastors, care for their service users experiencing mental health problems is usually informed by the Christian faith and methods (Murambidzi 2016:74). While such religious interventions have some value, they may be limited when used alone considering that health and wellbeing are influenced by an interplay of biopsychosocial and spiritual factors (Mauda 2022: 205). Therefore, managing congregants with mental

health problems may require formal collaborations between all important mental health role players. In the context of this study, it thus suffices to have pastors and MHCPs collaborate in the care and treatment of their service users. This is because more often, MHCPs and pastors use different methods and resources in the process of helping those who consult with them. Given the above, there is a need for both pastors and MHCPs to acknowledge each other's expertise and shortcomings if collaboration is to be realised (Mabitsela 2003:97). The present study sought to explore black Pentecostal pastors' views regarding possible collaboration between themselves and MHCPs.

Religion and spirituality are still to a great extent left out in the conception and management of mental health problems (Koenig 2012:14). A practice which is in stark contrast to reality on the ground as was highlighted in the preceding section. The neglect of faith and its influences to mental health has continued to limit the delivery of integrated or holistic mental health interventions. In a typical hospital setting, multi-disciplinary mental health care panels lack the participation of any type of spiritual practitioners including pastors (Greyvenstein 2018:4). Empirical studies (e.g., Hefti 2011; Saad *et al.* 2017) have supported their inclusion in such teams to help achieve holistic care of service users. Faith practitioners are also experts and sources of information required for efficient delivery of holistic health services (Greyvenstein 2018:4). Undeniably, there are valuable lessons that all involved in mental health care delivery could learn from each other if they were to collaborate. Mohr (2011:552) sustains this argument by indicating that to integrate spirituality into treatment, western trained health care practitioners needed to be open, sensitive, and willing to learn about the role spirituality plays in their patients' lives. Given the above, a culturally competent therapist, should, at the very least, be willing to explore and address the influences of religious and spiritual beliefs on patients' health and wellbeing (Henderson 2018: 22).

Literature Review

Collaborative studies have tended to yield varying results overtime. Previous studies have demonstrated that Pentecostal pastors held varying attitudes towards collaborating with MCHPs. For example, while in the USA and UK pastors seem to be willing to collaborate with MHCPs (Leavey 2010: 18), in some African countries, the position seems to be different. A study by Kpobi and Swartz (2018a: 2) in Ghana displayed a strong desire to be formally recognised for their work and abilities, suggesting that they perceived

themselves as equally knowledgeable and skilled in mental health issues. Based on that understanding, many of them envisioned a system in which they worked alongside doctors to provide services to patients in hospitals. The study by Kpobi and Swartz (2018a : 2) also found that although Pentecostal pastors acknowledge the place of biomedicine, they held a view that their methods work better than biomedical methods. While this is the case, documented evidence also suggests that, unlike MHCPs, some religious and spiritual professionals are open to collaboration (e.g., Hardwick 2013: 154; Okello, Sirera & Otieno 2021: 37-38). As for pastors, while studies continued to yield varying views, but it is evident that they are more open to collaborating with MHCPs of the Christian background (Hardwick 2013), yet not open to do so with African spiritualists (Mulutsi 2021: 59).

Regarding collaboration between MCHPs and pastors, a study by Kamanga *et al.* (2019:51) revealed that pastors believed that there was no trust between doctors and pastors. Equally, pastors were suspicious that doctors undermined them for they lacked knowledge regarding the pathophysiology of mental illnesses. Doctors were also perceived to lack faith in the power of God. For instance, a pastor who took part in Kamanga and colleagues' study specifically said: *'Health professionals and pastors do not trust each other hence it is difficult to work together and refer patients to each other for more holistic care'*. A 2022 meeting convened by the American Psychiatry Associations' foundation brought together 'leaders of multiple faith traditions, psychiatrists, and mental health professionals to discuss how they might better work together to promote well-being among patients, members of various faiths, and themselves' (Carr 2022: 1). Essentially, despite the various barriers and widespread scepticism between healers from each end, formal collaboration seems to hold a promise including expanding reach of mental health care (Ae-Ngibise *et al.* 2010; Carr 2022;). What is promising is that most Black Pentecostal pastors acknowledge that there was a need for themselves and MHCPs to collaborate (Ae-Ngibise *et al.* 2010).

Pentecostal Pastors' Preferences Regarding Collaboration with MHCPs

Studies exploring pastors' views regarding collaboration in the South African context are generally lacking. One study discovered that pastors advocated for faith-based treatments to be included in mental health care, whilst they also showed preference towards intra-collaborations with Christian oriented health

professionals (see Kruger 2012: 68). Likewise, in America, Stanford and Philpott (2011: 288) found that Baptist senior pastors were likely to refer their congregants to MHCPs they knew to be Christian. While these studies help shed some light on this phenomenon, both are outdated. Another limitation, regarding Kruger's 2012 study is that, the study was carried out in an urban and affluent setting with Afrikaans speaking church leaders who possessed at least a Bachelor's degree in theology, something which many Black Pentecostal pastors lack. As such, Kruger's study cannot be taken to be representtative of the voices of all pastors operating in the South African context.

A recent study by Okello and colleagues (2021:38) in Kenya revealed that pastors indeed preferred referring people with mental health problems to other pastors, something coined, intra-referral. This study replicated findings of an earlier study by Ae-Ngibise *et al.* (2010:563), which revealed that many of the traditional healers and faith healers (pastors) shared the sentiments that they would normally refer a patient to another healer when they found the condition very difficult to manage. Another picture was painted earlier by Mabitsela (2003:93), whereby it was revealed that Black Pentecostal pastors collaborated with some categories of MHCPs. Specifically, Mabitsela's study revealed that Black Pentecostal pastors collaborated only with social workers and police officers as compared to psychologists. The participants in Mabitsela's study cited the following reasons for their reluctance to collaborate with other categories of MHCPs. Firstly, professional psychological services were seen as very expensive for most of their members. Secondly, majority of congregants (service users) were not familiar with western orientated mental health care services. Thirdly, psychological service facilities were not readily available in township and rural settings.

Pentecostal pastors seem to accuse psychologists of ignoring the influence of faith in mental health care but only concentrate physical and psychological factors (Mabitsela 2003:94). Although Mabitsela's study provided some insights into views of Black Pentecostal pastors, it was limited in terms of the sample size that was used and the place wherein it took place (Soshanguvhe, Tshwane, South Africa). As such, the findings cannot be extrapolated to the entirety of the pastoral population in South Africa yet the study was conducted almost twenty-two years ago. Certainly, there could be some paradigm shift regarding Black Pentecostal perceptions regarding collaboration with MHCPs. Generally, in the South African context, studies documenting the views of Black Pentecostal pastors' views on collaborating with MHCPs are scanty.

Theoretical Framework

This study was carried out within the Bio-Psycho-Social-Spiritual (BPSS) framework. The BPSS model of mental illness acknowledges the importance of biological, psychological, social, and spiritual factors as determinants of psychopathology (Sulmasy 2002:6). Thus, the BPSS model represents a much more acceptable and inclusive model of understanding mental illness**.** It is an extension to the widely used and existing Bio-Psycho-Social model coined by George Engel in 1977 (Hefti 2011:612). For this study, the model was chosen because it integrates religion/spirituality as a fourth dimension (Hefti 2011: 612) to interpret, assess, diagnose, and treat mental illness. According to Winiarski (1997:6-7) the BPSS model assists us in incorporating knowledge from other disciplines.

Moreover, the BPSS model provides a platform for various professionals to share and exchange knowledge, work in collaboration and above all displays their expertise for the common good of the patient. The BPSS model's multidimensional strategy aligns with contemporary ideas and intervention frameworks like the Task Shifting and Collaborative models, which advocate for enhancing mental health services by acknowledging and including non-specialist mental health providers (Murambidzi 2016:104).

Research Methodology

This study was undertaken under a qualitative research methodological approach. Qualitative research seeks to understand a given research problem or topic from the perspectives of the local population it involves (Mack *et al.* 2005:1). The exploratory research design was thus found appropriate since the study sought to explore and describe how Black Pentecostal pastors' views on regarding collaboration in mental health care. Participants for the present study were selected through the purposive sampling strategy. Participants were recruited by the first researcher, whose himself a Black Pentecostal pastor and a licenced clinical psychologist, through networks of leaders of the Limpopo Pastors' Fraternal body and the Polokwane United Pastors. Only the pastors who were willing to participate in the study were interviewed.

The participants were selected regardless of years of experience, size of congregation, educational qualification, gender, or socio-economic status of the church to ensure that there was variety with respect to the key factors in this study. Pentecostal churches are led by noticeably young pastors as compared to their counterparts in the mainline churches such as the Orthodox, Catho-

lics, Anglicans, and Lutherans (Kgatle 2022:5). Data were gathered using semi-structured in-depth interviews. A total of nineteen (19) pastors were interviewed. Thirteen of the participants were interviewed in English as their preferred language while six were interviewed in Sepedi, the dominant local language in Polokwane. Amongst the 19 participants, Sixteen (16) of the participants were male, while only 3 were females. Each interview took approximately 45-60 minutes.

Face-to-face interviews were conducted in a non-directive style and a semi-structured interview guide facilitated the interviewing. The guide consisted of open-ended questions which were used to elicit the participant's views regarding collaboration. Data derived through the semi-structured individual interviews were analysed through Thematic Analysis (TA). TA is a method for identifying, analysing, and reporting patterns (themes) within data. The audio-taped interviews were transcribed by the researcher and in the process, listening to each interview, typing out each word verbatim. For validity checking, some of the participants were telephonically contacted to verify what they had said during the interviews. After the initial transcriptions, the transcripts were reviewed by an independent reviewer.

The Sepedi interviews were first transcribed in vernacular language by research assistants and were then translated to English by an experienced language translator and senior lecturer. Subsequently, the interviews were analysed through TA which is a method for identifying, analysing, and reporting patterns (themes) within data. In the process, the researcher adopted the following steps of inductive data analysis as adopted from Braun and Clark (2006:79). This method enabled us to: familiarise ourselves with our data, generate initial codes, searching for themes, review them and define and name them. The last stage was for the researchers to summarise the principal themes, analytic narrative, and data extracts and produce a report.

Ethical Considerations

Permission for the Study

For the purposes of this study, permission was sought and obtained from University of Limpopo's Turfloop Research Ethics Committee (TREC) prior the commencement of the study. Permission was granted on the 20/02/2019 and the project number as TREC/02/2019. The researcher also approached the Limpopo Pastors' Fraternal for permission to interview their affiliates. The

researcher was then sent a data base of the Limpopo Pastors' Fraternal and Polokwane United Pastors (PUP) affiliated pastors.

Informed Consent

Research participants are entitled to full information regarding the reasons, aims and purpose of an investigation (Christensen, Jonson & Turner 2014: 260). When contacting the potential participants for this study, the researcher fully identified himself with the study participants and the participants were briefed about the nature and purpose of the study. The participants who accepted to participate in this study were requested to sign a Consent Form to ensure that they agreed to participate in the study. Furthermore, prospective participants were informed that participating in this study is voluntary and they could withdraw from the study at any time they wished to during data collection. The researcher also openly discussed with the participants the potential benefits and risks associated with participating in the study and that there were no monetary gains for participating in the study. In addition, the participants were also informed of how data from the study would be used in the research.

Confidentiality and Privacy

Coffelt (2017:1) defines confidentiality as separating or modifying any personal, identifying information provided by the participants from the data. Thus, the researcher has the responsibility to protect the participant from harm by altering any identifying personal information that may be revealed during the interview. The issue of confidentiality and dissemination of information was discussed with the participants before the interviews were conducted. Further, participants were assured that their names and identities will remain anonymous and confidential throughout the research process. In this study, the researchers did not mention names of the participants or the names of their churches or location. Instead, Code names were used. Furthermore, all audio tapes and recordings were destroyed after the analysis of results was concluded. Research data was always stored on a password protected computer which was kept in the researcher's office. To ensure privacy in this study, the participants were interviewed privately in their church offices and homes. Thus, the participant was not interviewed in a group setting.

Debriefing for Participants

The researcher was aware that the research could lead to discomfort and some emotional reactions by some participants. In an event where any of the above happens, affected participants were to be referred for debriefing to psychologists in the local hospitals. In addition, the researcher would debrief participants who report being distressed by the interview process. However, besides some occasional emotional comments on past experiences with mentally ill persons, neither overt nor covert emotional distresses were registered and none of the participants opted to end the interview due to the increasing distress.

Findings

The aim of this study was to explore and understand the perceptions of Black Pentecostal pastors regarding possible collaboration with MHCP in the treatment and management of mental health problems. A total number of 19 participants took part in this study. Of the 19, 16 were males while only 3 were females. Three major themes emerged from the data. The themes were as follows: (a) Pastors' expressed willingness to collaborate with MHCPs; (b) Pastors are willing to collaborate with MHCPs of all religious backgrounds; and (c) Pastors considered several factors before referring service users to MHCPs.

Pastors' Expressed Willingness to Collaborate with MHCPs

An overwhelming majority of participants held a positive attitude towards collaborating with professionals in mental health care. Evident in the data was that some pastors had already made referrals to MHCPs yet others had ongoing informal collaborations. What is also evident in the data is the one-directional nature of referrals, that is, pastors were the only ones referring patients. It is in this regard that the participants emphasised on the need for bi-directional referral systems for improved care of service users. Furthermore, the most indicated that MHCPs were scientific experts endowed with special abilities to treat mental illness by God, hence they were willing to collaborate with them. This finding is echoed by the pastors' voices herein:

> *I have no problems with professionals. They are doing their job. And they must do their job. That is why I said, as for me, If I pray for*

> *somebody, if I see that this person is healed, I want her to go back and be checked by the doctor so that she can also have confidence that she is fine* **(Participant 8, Female, 46 yrs).**

> *I will refer them to those people because they are educated to help people's lives, we are …. in fact we are working hand in glove as a unit* (**Participant 1, Male, 35 yrs).**

> *… I don't have a problem …. Even if it were not mental illness, I could still send them to hospitals because I think those are the relevant people that can assist in those areas* **(Participant 9, Male, 35 yrs).**

While it is evident in the data that pastors held a positive attitude towards collaborating with MHCPs, a few others had some ambivalence.

> *There is no need for us to work together or collaborate. You know why? As a pastor, I do not force a person that I should pray for them* **(Participant 3, Male, 32 yrs).**

> *Yes, for something like an accident or physical injury, but I have never seen a case that I would say I had to refer to the hospital* **(Participant 19, Male, 50 yrs).**

Pastors are Willing to Collaborate with MHCPs of All Religious Backgrounds

It also emerged that Black Pentecostal pastors were willing to collaborate with MHCPs irrespective of their religious background. While this was the case, some pastors maintained that if the MHCPs and themselves shared the same faith, it even had some added advantage. The following extracts lend support:

> *Our faith, whether you believe in what we believe in, is not a factor. But if we happen to find that s/he is one from our faith, then that is an added advantage, but that is not what we pursue. That is not our criteria* **(Participant 17, Male, 49 yrs).**

> *To be honest. I really do not care (giggles) whether they are in the same faith with me or not* **(Participant 7, Male, 51yrs).**

> *I wouldn't necessarily want to say that I do that, or those issues of religion or faith. There are doctors that are not Christians but are particularly good in what they do* **(Participant 14, Female, 31 yrs).**

> *No, many are times, I do not look at the fact that the professional is from the same faith with me. It is just a matter of saying, 'Go to health professionals, they will help you* **(Participant 16, Male, 38 yrs).**

The data also revealed that while the pastors were willing to collaborate with mental health providers who did not practice their religion, they still preferred those of their religious background.

> *We prefer to send those people to those with the same faith as we have. We prefer to send them there because we do not want different knowledge. We want the same knowledge that we have for those people to give them the same material that we have* **(Participant 5, Male, 31).**

> *I always prefer to refer to those who are of the same faith because, when you refer someone, instead of criticising or destroying the individual because of where the referral is coming from, they will be keen to help* **(Participant 4, Male, 39).**

> *There is a specific person that we know that they will understand both the spiritual and the psychological. So, we refer, and we also help as we refer, we talk to that person* **(Participant 10, Female, 52 yrs).**

> *Yes. I do. I normally prefer medical doctors that are born again because those who are not born again, they do not understand that there are demonic attacks* **(Participant 11, Male, 47 yrs).**

> *Yes. In the same faith because I do not think I can take somebody to a different faith from mine* **(Participant 12, Male, 53 yrs).**

> *Yes, the one I work with is a pastor. We share the same faith. Even when he is treating people, he also understands that he will pray first before counselling the people, before doing anything and will even advise family members that, you see such cases, I am a medical officer, I have this profession but you see, because I am a pastor and*

> *I understand these things, such cases sometimes need prayers* **(Participant 13, Male, 29 yrs).**

Pastors Considered Several Factors before Referring Service Users to MHCPs

Several factors were reportedly influential to pastors' decision to refer service users to MCHPs. More amplified were the influential role of families of service users, accessibility of MHCPs relative to the church's geographical location, understanding that mental illness resulted from an interplay of factors, and cost of professional health care services. The following extracts amplify the determining factors influential to pastors referral of service users to MCHPs:

> *It all depends on the family like I said, because they are the one who incur the costs. We give the family that latitude. But we just say to the family take them to the psychiatrist. We may not have the list of them. But we just in]dicate to the family that this case needs a psychiatrist* **(Participant 7, Male, 51yrs).**

> *If it is somebody reachable, then I can recommend that one. But if they are no reachable, I can recommend to any* **(Participant 9, Male, 35 yrs).**

> *And, health professionals are supposed to play a role, since they can know and are experienced a lot. Above all, mental illness has multiple causes* **(Participant 18, Male, 54 yrs).**

> *I think it is a good thing because like I said, not everything is totally spiritual. As a lay person, you will only know a few things but when you take somebody to health professionals, you find that they are helpful* **(Participant 10, Female, 52 yrs).**

The study data evidently reveals that Black Pentacostal Pastors have a positive attitude towards collaborating with MHCPs in the management of mental health. More obvious in the data, is their willingness or preferential attitude towards collaborating with MHCPs of the same religious background. Whilst this is the case, numerous factors went onto influence their decision making process.

Discussion of Findings

The aim of this study was to explore and describe Pentecostal pastors' views regarding possible collaboration with MHCPs. In the main, study findings revealed that Pentecostal pastors held mixed views regarding collaboration with MHCPs, even though most supported the move towards formal collaborations. While some pastors have started referring service users to MHCPs, the latter were not reciprocating the referrals. The study findings replicate previous findings regarding Pentecostal pastors' willingness to collaborate in mental health care inspite of a few not in support (Hardwick 2013: Okello *et al.* 2021; Kpobi & Swartz 2018a). What seems to influence the positive attitude towards collaboration is that pastors have long understood that mental illness is influenced by an interplay of biological, psychological, social and spiritual factors (Kruger 2012:66). It is in this regard that some pastors operated within the confines of the Bio-Psycho-Social-Spiritual (BPSS) paradigm of mental illness, which could also explain why some are reported to have been referring their service users to their counterparts (Stanford & Philpott 2011: 288; Mabitsela 2003;93).

Further support comes from Payne (2009:362) who has long reported that pastors who are able to utilise their spiritual expertise, and refer out when needed, prove to be extremely effective service providers. Meanwhile, the demonstrated negative attitude towards collaboration by some pastors could be revealing of their limited insight regarding holism and mental illness causality explanations. Regretably, such pastors akin to MHCPs who have previously been reported to have a negative attitude towards collaborating with other stakeholders (Kmanga *et al.* 2019; Sullivan *et al.* 2013), could potentially sabotage efforts towards formal collaborations while hindering optimal or holistic interventions for service users (Payne 2009 : 363). Besides, what may appear as a negative attitude towards collaboration may as well be a defensive strategy revealing their lack of insight regarding the influences of belief and culture in mental health. Previous studies (e.g., Kamanga *et al.* 2019; Sullivan *et al.* 2013) lend support to this assertion. For instance, a study by Osafo (2016: 498) revealed that MHCPs lacked knowledge on the influence of belief and culture on mental illness and management. It therefore becomes prudent that efforts be targeted at addressing this weakness. It is necessary for both pastors and professionals to continue sharing spaces and champion the collaborative imperative to help bridge the knowledge gap (Rogers *et al.* 2013; Rudolfsson & Milstein 2019).

More importantly, professional training programmes needed to revise their curricula to include the influences of religion, spirituality and culture. Specifically because the influence of belief and culture needed to be considered from the point of assessment to treatment planning and intervention (Grossklauss 2015:34). Several researchers and health practitioners (e.g. Janse van Rensburg *et al.* 2014:44; Hefti 2011: 612) have noted and advocated the same before. This is crucial in that formal collaborations have the potential to improve mental health care delivery and close the widening treatment gap especially in South Africa and other LMICs where available mental health services are inadequate.

The BPSS model emerges as a promising framework to guide mental health care provision in modern times (Moteiro 2015:86). Essentially, the BPSS model acknowledges diversity of cultures and religions (Monteiro 2015:87). The multidimensional nature of the BPSS model resonates with current thinking and intervention models such as the Task shifting and Collaborative models which posit the scaling up of mental health services through the recognition and involvement of other non-specialist mental health providers (Murambidzi 2016:104).

Collaborative conversations between all important mental health stakeholders need to be sustained especially with governments taking a leading role. This will help inform policy and strategy development while also responding to any challenges that could seek to regress efforts towards achieving holistic mental health care systems of care (Carr 2022; Ae-Ngibise *et al.* 2010). Such efforts could also help bridge the divide between service providers including mitigating the existing intra-and-inter stigmatising attitudes (Sullivan *et al.* 2013:10). Another factor worthy of research attention is the significance of collaboration on the basis of homophily, i.e., like mindedness or similar beliefs (Hardwick 2013; Okello *et al.* 2021:38). As was evident in this study, while the pastors were open to collaborating with MHCPs irrespective of cultural background, it was evident that they preferred Christian oriented health practitioners. One argument that was offered for this preference relates to the fact that like-mindedness constituted an advantage for all sharing the same faith in mental health care (Hardwick 2013:3; Kruger 2012:66). The argument of whether sharing similar beliefs constituted an opportunity or challenge requires further scientific investigation. Equally, how factors such as the costs of professional psychological services, inaccessibility of MHCPs especially in rural areas, and service user socio-economic status influence collaborative efforts (Murambidzi 2016:83; Mabitsela 2003:94) require

continuous interrogation, with government having to play an important role.

Conclusion

The present study established that Black Pentecostal pastors although they held varying perceptions regarding collaboration, they mostly held a positive attitude towards the imperative. While several challenges (i.e., practitioner negative attitudes towards each other, preference on the basis of shared belief, cost and accessibility of professional services) still confront efforts towards collaboration, through cross-functional knowledge sharing practices and government support the challenges can be mitigated. In this study, the findings signify a clarion call for MHCPs and pastors including other stakeholders to work together for a common course. In light of the study findings, MHCPs should be willing to share with pastors some basic knowledge about mental illness and treatment from biomedical perspectives. Similarly, Black Pentecostal pastors should avail themselves to educate MHCPs about their Christian approaches towards understanding and managing mental health problems. Such efforts could help inform policy, mental health curricula, and strategies, all of which, could contribute towards expanding reach of mental health care or ushering in holistic mental health care systems.

Study Recommendations and Implications

Based on the findings of this study, it is evident that the South African government should be playing a leading role or facilitating the collaboration agenda. Clear policy and strategy are necessary seeing that on the pastors' side, they support collaborations with MHCPs. Through relevant government departments and institutions, there should also be monitoring and support to enhance a move towards collaborative interventions in mental health care in South Africa. Educational spaces between all important stakeholders particularly health care providers should be encouraged and sustained. These could be important avenues for attitudinal change and cross-functional knowledge sharing to be achieved. Future research could also be conducted with pastors and other mental health stakeholders to help inform best practices and a responsive mental health curricula. Essentially, the major implications of the present study are two folds; a) from Black Pentecostal pastors perspective, there's room for collaboration with MHCPs, however, the latter should also be willing to collaborate, and b) there's an urgent need for the government to

guide strategy on achieving this collaboaration while also making it possible for mental health care services to be easily accessible and affordable. These are aspects which could impact positively on service users' access to holistic health care services in contemporary South African context. The BPSS emerges as a promising framework to guide policy, strategy, and formulation of holistic mental health interventions. More collaborative studies employing the BPSS as the guiding framework are recommended. Such a consideration could also help test the theory's explanatory power.

Acknowledgements
The authors would like to thank God for the strength and divine ability to complete this project. Furthermore, the Pentecostal pastors in Polokwane who willingly participated in this study. Over and above, The financial assistance of the National Institute for the Humanities and Social Sciences (NIHSS), in collaboration with the South African Humanities Deans Association (SAHUDA) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the authors and are not necessarily to be attributed to the NIHSS and SAHUDA.

Competing Interests
The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper**.**

Disclaimer
This paper represents the opinions of the participants who took part in the main study, and is the product of professional research. It is not meant to represent the opinions of the authors or the NIHSS.

References

Ae-Ngibise, K., S. Cooper, E. Adiibokah, B. Akpalu, C. Lund, V. Doku & The MHAPP Research Consortium 2010. 'Whether you like it or not, people with mental problems are going to go to them': A Qualitative Exploration into the Widespread Use of Traditional and Faith Healers in the Provision of Mental Health Care in Ghana. *International Review Psychiatry* 22,6:

558 - 567. https://doi.org/10.3109/09540261.2010.536149. Available at: https://pubmed.ncbib.nlm.nih.gov (Accessed on 17 June 2018.)

Carr, J., December 2022. Partnership between Psychiatrists, Faith Leaders, Untapped Key to Expanding Reach of Mental Healthcare. *Psychiatric News* PN, 57:12. Available at: https://psychiatryonline.org/ (Accessed on 15 January 2025.)

Cofflet, T.A. 2017. Confidentiality and Anonymity of Participants. In Allen, M. (ed.): *The SAGE Encyclopedia of Communication Research Methods.* London & New Delhi: Sage.

Dein, S. 2017. Against the Stream: Religion and Mental Health - The Case for the Inclusion of Religion and Spirituality into Psychiatric Care. *British Journal of Psychiatry* 42,3: 127 - 129. https://doi.org/10.1192/bjb.2017.13 Available at: https://pmc.ncbi.nlm.nih.gov/articles; PMid:29761753 PMCid:PMC6048728 (Accessed on 13 January 2025.)

Greyvenstein, W. 2018. *The Interface of Religion, Spirituality and Mental Health within the South African Context.* (Publication No10500/27122.) Doctoral Thesis, University of South Africa. Available at: http://uir.unisa.ac.za/bitstream/handle/10500/271 (Accessed on 12 February 2022.)

Grossklaus, M. 2015 . Free Church Pastors in Germany – Perceptions of Spirit Possession and Mental Illness. (Publication No. 10500/55685.) Doctoral Thesis, University of South Africa. Available at: http://uir.unisa.ac.za/handle/10500/22658 (Accessed on 15 July 2021.)

Hardwick, K.L. 2013. Apostolic Pentecostal Pastors' Beliefs Regarding Mental Health Disorders. (Publication No. 1367943471.) Doctoral thesis, University of Cincinnati.Available at: https://etd.ohiolink.edu/!etd.send_file?accession=ucin1367943471&disposition=inline (Accessed on 18 July 2019.)

Hefti, R. 2011. Integrating Religion and Spirituality into Mental Health Care. *Psychiatry, Psychotherapy & Religions* 2,4: 611 - 627. https://doi.org/10.3390/rel2040611 Available at: www.mdpi.com (Accessed on 03 May 2018)

Henderson, T.E. 2018. The Influence of Therapist – Patient Religious/ Spiritual Congruence on Satisfaction with Therapy: A Review of Research. (Publication No. 2553.) Masters dissertation, Rowan University. Available at: https://rdw.rowan.edu/etd/2553 (Accessed 03 May 2018.)

Jackson, K.L. 2017. A Qualitative Study Understanding the Perceptions of

Black Pentecostal Pastors towards Mental Health and Collaborating with Mental Health Counsellors. (Publication No. 1490737370233102.) Doctoral thesis, Ohio University. Available at: https://etd.ohiolink.edu/ (Accessed on 4 April 2019)

Jackson, K.L. 2017. A qualitative study understanding the perceptions of Black Pentecostal pastors towards mental health and collaborating with mental health counsellors. (Publication No.1490737370233102.) Doctoral thesis, Ohio University. Available at: https://etd.ohiolink.edu/ (Accessed on 16 October 2024)

Kamanga C.N., H.K. Chilale, L.Z. Mugala & C.B. Maloya 2019. Exploring the Concept of Mental Health and Healing among Pastors in Mzuzu and Possible Collaboration with Mental Health Professionals. *International Journal of Internal Medical Geriatrics* 1,2: 46 - 53. Available at: www.scitcentral.com (Accessed on 05 June 2020.)

Kgatle, M.S. 2022. The Newer Non-Denominational Pentecostal Churches in South Africa: A Critical Approach to Non-Denominationalism in Pentecostalism. *Studia Historiae Ecclesiasticae* 49,3: 14 pages. Available at: https://uir.unisa.ac.za (Accessed on 14 January 2025.) https://doi.org/10.25159/2412-4265/10997

Koenig, H.G. 2012. Religion, Spirituality and Health: The Research and Clinical Implications. *International Scholarly Research Network (ISRN) Psychiatry* 278730: 1 - 33. https://doi.org/10.5402/2012/278730 Available at: PMid:23762764 PMCid:PMC3671693 (Accessed on 13 February 2019.)

Koenig, H.G., N.A. Youssef & M. Pearce 2019. Assessment of Moral Injury in Veterans and Active Duty Military Personnel with PTSD, A Review. *Frontiers in Psychiatry* 10: 443. Available at: https://www.frontiersin.org/journals/psyhchiatry/articles/10.3389/fpsyt.2019.00443/ful; https://doi.org/10.3389/fpsyt.2019.00443 PMid:31316405 PMCid:PMC6611155 (Accessed on 19 July 2023.)

Kpobi, L.N. & L. Swartz 2018a. Implications of Healing Power and Positioning for Collaboration between Formal Mental Health Services and Traditional/ Alternative Medicine: The Case of Ghana. *Global Health Action* 11,1: 6.2018.1445333. https://doi.org/10.1080/1654971 Available at https://pubmed.ncbi.nlm.nih.gov (https://doi.org/10.1080/16549716.2018.1445333 PMid:29529937 PMCid:PMC5912442 (Accessed on 18 February 2020.)

Kpobi, L.N. & L. Swartz 2018b. 'The threads in his mind have torn': Concep-

tualization and Treatment of Mental Disorders by Neo-prophetic Christian Healers in Accra, Ghana. *International Journal of Mental Health Systems* 12,40: 1 – 12. Available at: https://doi.org/10.1186/s13033-018-0222-2 PMid:30061921 PMCid:PMC6056911 (Accessed on 09 August 2024.)

Kruger, Q. 2012. *Treatment of Mental Illness by Afrikaans Speaking Church Leaders in Polokwane, Limpopo Province*. Unpublished Masters Dissertation, University of Limpopo. Available at: https://ulspace.ul.ac.za-Kruger_q_2012 (Accessed on 19 September 2024.

Janse van Rensburg, B.A., M. Poggenpoel, C.P. Myburg & C.P. Szabo 2014. A Model for the Role of Defined Spirituality in South African Specialist Psychiatric Practice and Training. *Journal of Religion & Health* 53,2: 393 - 412. Available at: https://pubmed.ncbi.nlm.nih.gov https://doi.org/10.1007/s10943-012-9644-3 PMid:23099614 (Accessed on 16 January 2025.

Kumar, V. 2018. The Role of Religion and Spirituality in Mental Health: A Review. *Phonix - International Journal for Psychology & Social Sciences* 2456 (5180): 68 - 85. Available at: http://www.phonixcentre.in/journals.php (Accessed on 15 January 2025.)

Leavey, G. 2010. The Appreciation of the Spiritual in Mental Illness: A Qualitative Study of Beliefs among Pastors in the United Kingdom. *Transcultural Psychiatry* 47,4: 571 - 590. https://doi.org/10.1177/1363461510383200 Available at: https://pubmed.ncbi.nlm.nih.gov (Accessed on 9 August 2023.)

Llyod, C.E.M., J. Cathcart, M. Connolly-Panagopolous & G. Reid 2023. The Experiences of Faith and Church Community among Christian Adults with Mental Illness: A Qualitative Metasynthesis. *Psychology of Religion & Spirituality* 16,4: 352 - 366. http://dx.doi.org/10.1037/rel0000511 (Accessed on 18 February 2024.)

Luchetti, G., H.G. Koenig & A.L.G. Luchetti 2021. Spirituality, Religiousness and Mental Health: A Review of the Current Scientific Evidence. *World Journal of Clinical Cases* 9,26: 7620 - 7631. Available at: https://pmc.ncbi.nlm.nih.gov; https://doi.org/10.12998/wjcc.v9.i26.7620 PMid:34621814 PMCid:PMC8462234 (Accessed on 8 August 2024.)

Mabitsela, L. 2003. Exploratory Study of Psychological Distress as Understood by Pentecostal Pastors. (Publication No.2263/30114.) Masters dissertation, University of Pretoria. Available at:

https://repository.up.ac.za/bitstream/handle/2263/30114/Complete.pdf?sequence=10 (Accessed on 17 May 2018.)

Mack, N., C. Woodsong, K. Mcqueen, G. Guest & E. Namey 2005. *Qualitative Research Methods: A Data Collector Field Guide.* Family Health International. Available at: https://www.fhi360.org/sites/default/files/media/documents/Qualitative%20Research%20Methods%20-%20A%20Data%20Collector%27s%20Field%20Guide.pdf (Accessed on 13 June 2018.)

Manerikaar, V. & S. Manerikaar 2014. A Note on Exploratory Research. https://www.semanticscholar.org (Accessed on 13 June 2018.)

Mauda, L.T. 2022. *The Perception and Treatment of Mental Illness by Selected Pentecostal Pastors in Polokwane: Towards an Intervention Programme.* Doctoral Thesis, University of Limpopo. Available at: https://www.ulspace.ul.ac.za-mauda_lt_2022 (Accessed on 14 September 2022.)

Mohr, S. 2011. Integration of Spirituality and Religion in the Care of Patients with Severe Mental Disorders. *Religions* 2,4: 549 - 565. https://doi.org/10.3390/rel2040549 Available at: https://mdpi.com/2077-1444/2/4/549 (Accessed on 24 November 2024.)

Monterio, N.M. 2015. Addressing Mental Illness in Africa: Global Health Challenges and Local Opportunities. *Community Psychology in Global Perspective* 1,2: 78 – 95. https://doi.org/10.1285/i24212113v1i2p78 Available at: www.researchgate.net (Accessed on 21 June 2024.

Murambidzi, I. 2016. *Conceptualisation of Mental Illness among Christian Clergy in Harare, Zimbabwe.* (Publication No.11427/23421.) Master's dissertation, University of Cape Town. https://open.uct.ac.za/bitstream/handle/11427/23421/thesis_hsf

Okello, N., M. Sirera & G.O. Otieno 2021. Perceptions of Clergy on Collaboration with Psychological Counsellors in Management of Mental Health: A Focus on the Anglican Church of Kenya, Nairobi Diocese. *Journal of Sociology, Psychology & Religious Studies* 3,1. Available at: www.stratfordjournal.org (Accessed on 14 January 2025.)

Osafo, J. 2016. Seeking Paths for Collaboration between Religious Leaders and Mental Health Professionals in Ghana. *Pastoral Psychology* 65: 493 - 508. Available at: https://doi.org/10.1007/s11089-016-0703-7 (Accessed on 14 January 2025.)

Parks, A. 2020. *Mental Illness and Demonic Influence: The Difference between Them and the Difference it Makes.* (Publication No. 2581.) Doctoral thesis, Liberty University School of Divinity. https://digitalcommons.liberty.edu/doctoral/2581/

Payne, J.S. 2009. Variations in Pastors' Perceptions of the Aetiology of Depression by Race and Religious Affiliation. *Community Mental Health Journal* 45,5: 355 – 365. https://doi.org/10.1007/s10597-009-9210-y PMid:19533347 PMCid:PMC2758213

Rogers, E.B., E. Yuvarajan & M.S. Stanford 2013. The Clergy – Psychologist Relationship: Suggestions for Building an Interpersonal Collaboration. *Family & Community Ministries* 26: 1 - 25. Available at: http://steppingstonehouston.com/wp-content/uploads/2015/10/Rogers-Yuvarajan-Stanford-2013.pdf (Accessed on 14 January 2021.)

Rudolfsson, L. & G. Milstein 2019. Clergy and Mental Health Clinician Collaboration in Sweden: Pilot Survey of COPE. *Mental Health, Religion & Culture* 22,8: 805 - 818. Available at: https://doi.org/10.1080/13674676.2019.1666095 (Accessed on 9 October 2021.)

Saad, M.M., R. de Medeiros & A.C. Mosini 2017. Are we Ready for a True Biopsychosocial – Spiritual Model? The Many Meanings of 'Spiritual'. *Medicines* 4,79: 1 - 7. Available at: https://doi.org/10.3390/medicines4040079; PMid:29088101 PMCid:PMC5750603 (Accessed on 6 June 2020.)

Stanford, M. & D. Philpott 2011. Baptist Senior Pastors' Knowledge and Perceptions of Mental Illness. *Mental Health, Religion & Culture* 14,3: 281 - 290. Available at: https://doi.org/10.1080/13674670903511135 (Accessed on 20 October 2018.)

Sullivan, S., J.M. Pyne, A.M. Chenney, J. Hunt, T.F. Haynes & G. Sullivan 2013. The Pew versus the Couch: Relationship between Mental Health and Faith Communities and Lessons Learned from a VA/ Clergy Partnership Project. *Journal of Religious Health* 53,4: 1267 - 1282. https://doi.org/10.1007/s10943-013-9731-0 Available at: https://doi.org/ubmed.ncib.nlm.nih.gov; PMid:23775218 (Accessed on 13 June 2021.)

Sulmasy, D.P. 2002. A Biopsychosocial – Spiritual Model for the Care of Patients at the End of Life. *Gerontologist* 42,3: 24 - 33. https://doi.org/10.1093/geront/42.suppl_3.24 Available at: (Accessed on 16 March 2019.)

Vergese, A. Spirituality and Mental Health. *Indian Journal of Psychiatry* 50,4. Available at: https://journals.lww.com/indianjpsychiatry/fullt https://doi.org/10.4103/0019-5545.44742; PMid:19823605 PMCid:PMC2755140 (Accessed on 14 January 2025.)

Winiarski, M.G. 1997. Understanding HIV/ AIDS Using the Biopsychosocial/ Spiritual Model. In Winiarski, M.G. (ed.): *HIV Mental Health for the 21st Century*. New York University Press. https://doi.org/10.18574/nyu/9780814784600.003.0005

Dr. Lesley Takalani Mauda
Registered and Practicing Clinical Psychologist
Mankweng Tertiary and Academic Hospital &
Senior Pastor of Excellent Life Kingdom Church
Polokwane
takisibanda@gmail.com

Professor Mpsanyana Makgahlela
Registered Independent Clinical Psychologist
NIHSS Regional Mentor
Faculty of Humanities: Research and Postgraduate Office
University of Limpopo
Polokwane
Mpsanyana.Makgahlela@ul.ac.za