Pastoral care and counseling to people involved with faith healing within the belief systems of M.C.A.N and L.I.C

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DECLARATION

I, Edith Khakasa Chemorion declare that I have composed this thesis as my own original work. It is a presentation of my own original research work and that I have not submitted it in its entirety or in part to any institution for award of any degree or professional qualification. Wherever contributions of others are involved, every effort was made to acknowledge them.

DEDICATION

To all leaders giving Pastoral care and counseling in AICs.

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ABSTRACT

When people with belief systems in churches and communities find themselves in situations needing people to respond with pastoral caring support, justice can only be done when caregiving is competent, sensitive and contextual. On the one hand, Mission instituted churches (MICs) follow the models of pastoral care and counselling developed in the west. On the other hand, African Instituted churches (AICs) have caregiving approaches guided by among other things, beliefs, faith, caregivers, doctrinal teachings, values, founder's convictions, care resources and the history behind them. A dialogical engagement between Biblical Pastoral care and counselling, biomedical and existing models in AIC churches bring out Biblical principles and values that illuminates AICs caregiving approaches. This in a way sheds light to the gaps in AIC caregiving approaches. Doing so makes it possible to come up with relevant strategies of integrated Biblical Pastoral care and counselling that can address the identified gaps in caregiving, thus helping pastors and congregations to give sensitive, holistic and competent pastoral care in their churches.

This study researched pastoral care and counseling of people involved with faith healing within the belief systems of the L.I.C and M.C.A.N churches. This research aimed at investigating healing and care strategies to develop a pastoral care and pastoral counseling model to help people involved with faith healing within belief systems of the L.I.C and M.C.A.N churches. The primary question that guided this study is: 'What Model of Pastoral care and counseling would show pastors and congregations how to care for people involved with faith healing and belief systems of the L.I.C and M.C.A.N. churches?'

The study commences with a presentation of the introduction to the entire research and the statement of the problem as set out in chapter 1. The response to the primary question was enabled through the four main research objectives that took on the four tasks of practical theological research, as designed by Osmer. Chapter 2 is a description of faith healing and healing practices of people involved in L.I.C and M.C.A.N. The chapter responded to the question: 'What are the faith healing beliefs and healing practices of people in L.I.C and M.C.A.N?' This is an Empirical-Descriptive task, according to Osmer, which attempted to answer the question: 'What is going on?' To respond to the question, the researcher employed a mixed-method approach that contained quantitative and qualitative aspects. The researcher used a sample of 50 participants for the quantitative study using questionnaires with closed-ended questions. Out of the 50 participants, 15 participants also participated in the qualitative study in which open-ended questions were used. The data did not indicate any existing formal biblical pastoral care model in use in L.I.C and M.C.A.N.

The second task this study addresses in accordance with the four tasks of practical theological research as set out by Osmer, as reported on in Chapter 3, is the Interpretive task. The task presents the evaluation of the interdisciplinary models of biomedical and pastoral formal care being used in L.I.C and M.C.A.N. The question the chapter answered by means of the Interpretive task is: 'What are some of the models/methods from other disciplines used for caring for and counseling people with faith healing and belief systems?' A discussion was held concerning the relevance of biomedical models so as to ascertain their relevance in the care and counseling of people involved with faith healing within belief systems. Similarly, a comparative, dialogical approach was followed to bring under discussion Louw's Four-Stage model and Breed's Biblical model. Points of convergence and divergence between the models were presented. A context-sensitive approach for integration was used to establish points of linkage between the pastoral models of care and the African traditional counseling model as applied in Africa.

The Normative task, as proposed in Osmer's model, is performed in Chapter 4 to explore biblical perspectives, principles and values concerning care and counseling. The question this chapter answers, based on the fourth objective, is: 'What Biblical perspectives on Pastoral care and Counseling are available to those caring for people within the faith healing practices?' To answer the question, an exegesis was performed of the pericope Mk 5:25-34 by applying the historical critical and textual approach. The Biblical perspectives, principles and values presented were used to develop an integrated Biblical Pastoral Care and Counseling model to assist pastors and congregations in caring for people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

Chapter 5 covers the Pragmatic task, as described by Osmer. In this chapter, the ways of responding to the care and counseling needs are presented via the 'proposed integrated pastoral care and counseling model.' This is an answer to the chapter question: 'What pastoral care and counseling model would help the pastors and congregations in dealing with faith healing beliefs and healing practices in L.I.C and M.C.A.N? A full pragmatic response is reached at after having brought into discussion the data from the literature review on pastoral care and counseling, AIC care and counseling experiences, empirical study findings on faith healing practices in L.I.C and M.C.A.N, interdisciplinary models in pastoral care and counseling, and historical critical and textual exegesis of Mk 5:25-34. A conclusion to the study, lessons learnt, recommendations, and areas for further research are presented in chapter 6 of this study.

OPSOMMING

Wanneer mense met geloofstelsels in kerke en gemeenskappe hulself in situasies bevind wat mense nodig het om met pastorale omgee-ondersteuning te reageer, kan geregtigheid slegs gedoen word wanneer versorging bevoeg, sensitief en kontekstueel is. Aan die een kant volg Mission instituted kerke (MICC's) die modelle van pastorale sorg en berading wat in die weste ontwikkel is. Aan die ander kant het Afrika-ingestelde kerke (AID's) versorgingsbenaderings wat gelei word deur onder meer oortuigings, geloof, versorgers, leerstellige leerstellings, waardes, stigtersoortuigings, sorghulpbronne en die geskiedenis daaragter. 'N Dialoogbetrokkenheid tussen Bybelse Pastorale sorg en berading, en bestaande modelle bring Bybelse beginsels en waardes na vore wat AIC's se versorgingsbenaderings verlig. Dit werp op 'n manier lig op die gapings in AIC-versorgingsbenaderings. Deur dit te doen, maak dit moontlik om met strategieë van geïntegreerde Bybelse Pastorale sorg en berading vorendag te kom wat die geïdentifiseerde gapings in versorging kan aanspreek, dus om pastore en gemeentes te help om sensitiewe, holistiese en bekwame pastorale sorg in hul kerke te gee.

Hierdie studie het navorsing gedoen oor pastorale sorg en berading vir mense wat betrokke is by geloofsgenesing binne die geloofstelsels van die L.I.C- en M.C.A.N-kerke. Hierdie navorsing was daarop gerig om genesing- en sorgstrategieë te ondersoek om 'n pastorale sorg- en pastorale beradingsmodel te ontwikkel om mense wat by geloofsgenesing binne geloofstelsels van L.I.C- en M.C.A.N-kerke betrokke is, te help. Die primêre vraag wat hierdie studie gerig het, was: ‘Watter model van pastorale sorg en berading sou aan predikante en gemeentes wys hoe om vir mense te sorg wat betrokke is by geloofsgenesing en geloofstelsels van L.I.C- en M.C.A.N-kerke?’ Die studie is ingelui deur ’n inleiding tot die volledige navorsing en ook dié tot die beskrywing van die navorsingsprobleem in hoofstuk 1. Die navorsing oor die primêre vraag is gedoen aan die hand van die vier hoof-navorsingsdoelstellings wat volgens Osmer die vier take van prakties-teologiese navorsing is. Hoofstuk 2 is 'n beskrywing van geloofsgenesings- en genesingspraktyke van mense wat betrokke is by L.I.C en M.C.A.N. Die hoofstuk het die vraag: ‘Wat is die geloofsgenesings- en genesingspraktyke van mense in L.I.C en M.C.A.N?’ beantwoord. Dit is volgens Osmer 'n empiries beskrywende taak wat gepoog het om die volgende vraag te beantwoord: ‘Wat gaan aan?’ Om op die vraag te reageer het die navorser 'n gemengdemetode-benadering gevolg wat kwantitatiewe en kwalitatiewe aspekte ingespan het. Die navorser het 'n steekproef van 50 deelnemers gebruik vir die kwantitatiewe studie wat vraelyste met geslote vrae gebruik het. Van die 50 deelnemers het 15 ook deelgeneem aan die kwalitatiewe studie waarby oop vrae gebruik is.

Die data toon geen bestaande formele Bybels-pastorale sorgmodel wat in L.I.C en M.C.A.N gebruik word nie.

Die tweede taak wat hierdie studie ooreenkomstig Osmer se model in hoofstuk 3 onder die loep neem, is die interpretatiewe taak. Genoemde taak bied die evaluering aan van die interdissiplinêre modelle van biomediese en pastorale formele sorg wat in L.I.C en M.C.A.N gevolg word. Die vraag wat aan die hand van die interpretatiewe taak beantwoord is, is: 'Hoe lyk enkele modelle/metodes uit ander vakgebiede wat gebruik word vir die versorging en berading van mense wat by geloofsgenesings- en geloofstelsels betrokke is?' Die relevansie van biomediese modelle vir die versorging en berading van mense wat by geloofsgenesing binne geloofstelsels betrokke is, is bespreek. Eweneens is 'n vergelykende, dialogiese benadering gevolg om Louw se Vierstadium-model en Breed se Bybelse model in gesprek te bring. Punte van konvergensie en uiteenlopendheid tussen die modelle is aangebied. 'n Kontekssensitiewe benadering vir integrasie is gevolg om ooreenkomste tussen die pastorale versorgingsmodelle en die Afrika-tradisionele beradingsmodel te bepaal.

Die normatiewe taak, 'n stap in Osmer se model, geniet in hoofstuk 4 aandag met die oog daarop om Bybelse perspektiewe, beginsels en waardes rakende sorg en berading te ondersoek. Die vraag wat hierdie hoofstuk beantwoord, gebaseer op die vierde doelstelling, is: 'Watter Bybelse perspektiewe op pastorale sorg en berading is beskikbaar vir die versorging van mense binne die geloofsgenesingspraktyke?' Om hierdie vraag te beantwoord is 'n eksegese van Mk 5:25-34 gedoen, met behulp van die histories-kritiese en tekstuele benadering. Die Bybelse perspektiewe, beginsels wat ontdek is, is gebruik om 'n geïntegreerde Bybels-pastorale versorgings- en beradingsmodel te ontwikkel om predikante en gemeentes te help om mense te versorg wat betrokke is by geloofsgenesing binne die geloofstelsels van L.I.C en M.C.A.N.

Hoofstuk 5 is gemik op Osmer se pragmatiese taak. In hierdie hoofstuk word 'n geïntegreerde pastoralesorg- en beradingsmodel voorgestel. Dit is dus 'n antwoord op die hoofstukvraag: 'Watter pastoralesorg- en beradingsmodel sal die predikante en gemeentes help ten opsigte van die pastorale versorging van mense wat betrokke is by die geloofsgenesingsoortuigings en genesingspraktyke in L.I.C en M.C.A.N? Data uit die literatuuroorsig rakende pastorale sorg en berading, AIC-sorg- en beradingservarings, empiriese studiebevindinge oor geloofsgenesingspraktyke in L.I.C en M.C.A.N, interdissiplinêre modelle in pastorale sorg en berading,en histories-kritiese en tekstuele eksegese van Mk 5:25-34 is gebruik om die model te formuleer.

'n Opsomming van studieresultate, aanbevelings en areas vir verdere navorsing is in hoofstuk 6 van hierdie studie aangebied.

ABBREVIATIONS:

NWU- Northwest University
M.C.A.N- Muungano Church of all Nations
L.I.C- Lost Israelite church
A.O.H Avoidance of Harm
BPS- Biospychosocial
AICs- African Instituted Churches
R.E.B.T-Rational Emotive Behaviour Therapy
P.C.T-Person Centred Therapy
N.T- New Testament
O.T- Old Testament.
W.C.C- World Council of Churches
W.H.O- World Health Organization
ND-Non-direct Tehrapy
DT-Direct Therapy
ACA-American Counseling Association
BMM- Biomedical Model
CT- Cognitive Therapy
BC-Before Christ
BT- Behaviour Therapies
CBT- Cognitive Behaviour Therapies
CCT- Client Centred Therapies
SCB-Science and Christian Belief
MMR- Mixed Methods Research
YHWH-Yahweh
MCs- Mission Instituted Churches
PhD-Doctor of Philosophy
Ex-Exodus
Ps-Psalm
Jh
John
Heb-Hebrews
Phil-Phillipians
Cor-Corinthians
Eph-Ephesians
Lk-Luke
Mk Mark
Mt-Mathew

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CHAPTER 1: INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction

This chapter serves as an introduction to the study *Pastoral care and counseling to people involved with faith healing within Lost Israelites Church (L.I.C) and Muungano Church of All Nations (M.C.A.N) belief systems*. The researcher explained the key concepts that were used in the study, presented an introduction and the background to the study, formulated the research problem, research questions and objectives, and highlighted the central theoretical statement. The empirical research methodology used was the mixed method research approach that employs both quantitative and qualitative studies. Since this is a practical theological study, the researcher followed Osmer's four tasks in the practical meta-theoretical framework for practical theological research. Ethical guidelines that apply to human research were followed in this study.

1.1.1 Key Words

Faith Healing, Belief Systems, Pastoral Care, Pastoral Counseling, African Instituted Churches (A.I.Cs).

1.1.2 Definition of Key concepts

The researcher defined and gave meanings to the following key concepts used in this study: Faith Healing, Belief Systems, Pastoral Care, Pastoral Counseling. African Instituted Churches, an integrated approach, and Pastoral Care strategies.

1.1.3 Faith Healing

Healing is defined as the act of restoration of a loss and the search for integration and identity to retain what has been lost or to attain new coping skills, coping mechanisms or the reframing of existing concepts and ideas (Louw, 2008:75). Parsons (2002:147-148) also defines healing as the restoration to wholeness of a person that is suffering in mind or body. The Heidelberg Catechism (1981:36) presents faith as:

> true faith, which is not only knowledge and conviction that everything God reveals in his word is true; it is also deep-rooted assurance, created in me by the Holy Spirit through the gospel that out of sheer grace earned for us by Christ, not only others, but I too, have had my sins forgiven, have been forever made right with God, and have been granted salvation.

Therefore faith, which is viewed as spiritual energy, becomes a resource that makes the laws of the spiritual world function, where positive power is activated, and the negative is overcome.

Magezi (2016:2-3), Louw (2008), Takaaki & Elsdorfer (2012:157-167) and Masamba (2013:7-18) in Federschmidt, Temme, and Weiss (2013:7-137) all agree that for people on the African continent to seek divine healing, there is a challenge or struggle with illness. When life's challenges arise, people believe there is a cause, and one could trace it in the presence of diverse divinities, witches, wizards, the ancestral spirits, and other innumerable spirit-beings that are capable of obstructing the dealings of human beings. Illness and misfortune are linked to individual or group wrongdoings.

The illness and death of an individual is explained in terms of the result of an offence against the ancestors, violation of social taboos, an attack by deities and evil spirits, or the result of witchcraft. Sin is associated with the severing of prohibitions agreed on by the community or inherited from the ancestors. It is further argued that:

> African cosmology contains a constellation of powers that continually interact with human beings. These powers in African communities have a positive or negative impact and influence the path of lives of people. Holistic view of life means to 'be healthy and free from any sickness or life's challenges of any kind (e.g., healthy children, good marriage, stable job, being at peace with parents, etc). The wholeness of life entails being free and being at peace both physically and spiritually (Magezi, 2016:4).

Faith healing (which is also referred to as divine healing and the concern of this study) is understood to take many forms (in A.I.Cs) on the African continent and is popularly embraced among the countries. Healing may be instant, conditional or may need follow-up healing care. Some forms through which faith healing is effected in Ghana, as is in many parts of Africa include, but are not limited to, single remedies or combinations. Healing can be acquired through prayers, use of holy objects, visits to holy sites (shrines, forests, mountains, rivers, cemeteries), sacrifices, baths in rivers, through leadership of preachers, pastors, prophets, prayer warriors and prophetesses (Senah, 2006:62-68).

Magezi (2016:5-6) argues that giving care in African communities is expressed and practised by mixing African traditional practices and Christian pastoral care practices. Here, Pastoral care is concerned with addressing the spiritual causes of misfortune and restoring the person to full health. Similarly, pastoral care draws a dichotomy between Christian values and practical life as is acted upon by people in church communities, and also agonising and alienating Christianity where

church community members remain faithful to the gospel. The care also focuses on the formation of family and community coping with support structures in alternative family support through the church. It is similarly practised and expressed in the intentional family group enrichment by establishing youth, family, male and female groups to discuss and explore solutions to the challenges of life. Also important is the practice of exorcism and healing through which problems and any other life challenges attributed to curses and evil attacks are addressed. Pastoral care is conducted through the healing sessions and exorcism effected through persuading prayers over areas of concern. Finally, Pastoral care deals with persuading individuals who abandon Christian care and its approaches when faced with trouble, to retain their Christian faith and trust in Jesus.

1.1.4 Belief systems

Beliefs are the things or positions that people hold to be true to them. A belief is defined as anything a person thinks is true (Markham, 2002:30-31). Belief systems are structures of norms that are interrelated and that vary mainly in the degree to which they are systemic. These systems of belief are used by individuals to make sense of the world around them (Uso-Doménech & Nescolarde-Selva, 2016:147-152).

1.1.5 Pastoral care

Mills observed that pastoral care traditionally, and in the Christian community, falls within the cure-of-souls tradition. Pastoral care, known as *cura animarum* (which means cure of souls), implies the thorough care of people in their existential circumstances (Mills, 1990:836). Lartey (1997:23) says pastoral care is now clearly a communal congregational matter.

'Pastoral care'[1] and pastoral counseling are phrases that are occasionally used interchangeably. Pastoral care is the broad, all-encompassing ministry of shared healing and growth within a congregation and its community through its life cycle (Clinebell, 1984:26). Clinebell and McKeever (2011:9) see Christian pastoral care[2] as a shared ministry of clergy and laypersons,

[1] Pastoral care is seen in this study as pastoral caregiving that is about the total care of the church towards members and all people that they encounter. Pastoral counseling is part of pastoral care but focusses on a one to one (or small groups like families) conversation about a specific problem. Pastoral care which will also be referred to as Biblical pastoral care, uses the Bible as the word of God and appreciates its sufficiency for counseling. Christian counseling, which is done by a professional counsellor is a service where the counselee with a need goes to the professional counsellor for help. This is done from some perspective of the Bible as word of God only as it views scripture as inspiration, but selectively uses scriptural texts or not, but majorly appeals to secular methods and other sources outside the bible (see MacArthur,1997; Louw, 2014; Lambert, 2016).

[2] Christian pastoral care is seen as all care that is given in answer to the Bible as Word of God.

including those who receive training for this special ministry and the countless people who engage spontaneously in caregiving. They further say that pastoral care is the appropriate function of parish clergy, institutional chaplains and well-trained laity who understand it as being their ministry.

1.1.6 Pastoral counseling

Pastoral counseling is a specialised approach within general counseling and is defined as the art and skill of feeding or caring for the well-being of others, especially those who need it most (Louw, 2000:6). Similarly, Pastoral counseling, as one dimension of the pastoral ministry of the church, is the utilization of a variety of healing methods to help people deal with their problems and crises in a more effective manner and thus experience healing of their brokenness (Clinebell, 1984:26). McClure (2011:21) holds that pastoral counseling is a subset of pastoral care, or a specialised form of pastoral care. Hence pastoral counseling is a term used to denote a more narrowly defined relationship[3] between a pastor and a person. Clinebell & Mckeever (2011:9-10) defines pastoral counseling as 'a focussed form of pastoral care geared toward enabling individuals, couples or families to cope more constructively with crises, losses, difficult decisions, and other anxiety laden experiences.' Malureanu (2014:25) explains that 'pastoral counseling as a specialized type of pastoral care is the utilization by clergy of counseling and psychotherapeutic methods to enable individuals, couples and families to handle their personal crises and problems in living constructively.'

1.1.7 A.I.Cs (African instituted churches)

A.I.Cs, which are also referred to as African indigenous churches, are defined as churches that have been established by Africans and/or denomination planted, led, administered, supported propagated, instituted, and funded by Africans for the purpose of serving a true God (Oduro, 2008:31). Kgatle (2018:1) says, depending on one's perspective, the acronym A.I.C can stand for African indigenous churches, African independent churches, or African initiated churches. A.I.Cs were founded and run by Africans who succeeded in making the message of the gospel relevant to the African indigenous Worldview. WCC states that A.I.Cs have different names, but they all signal that they are independent in their origin and organization, and that they came into being through the initiative of Africans (WCC, 2013:8107). The understanding of the meaning of A.I.Cs is also

[3] Combs, A.W, Avila, D.L & Purkey, W.W.1978. Helping relationships basic concepts for the helping professions. 2nd (ed). Allyn and Bacon.

referred to by Chitando[4].

While there are different[5] denominations with different convictions such as churches that are conservative and reformed, Pentecostal/Charismatic churches with strong faith healing ministries, the white garment church and those that worship in the bushes and not in buildings, this study will focus on the L.I.C and M.C.A.N churches that form part of the A.I.Cs found in Kenya.

1.2 Background to the study- Analysis of A.I.Cs and Faith Healing

Western models of counseling as used by psychologists, psychiatrists, theologians, and philosophers have been used in counseling and psychotherapy worldwide. Mwiti and James (2013:72-82) maintain that most professional psychologists and counsellors in Africa south of the Sahara are trained in and utilize counseling models developed in the west. This is also echoed by Mucherera (2017: Viii) who adds that most books and other written material used for training counselors and pastoral caregivers in Africa are from the west. Further, Mucherera (2017:169) says pastoral caregivers serving in these contexts must be equipped with a pastoral and psychodynamic understanding of integrative consciousness. Models such as Person- Centred Therapy, Family systems therapies, Behaviour Therapies, Logo Therapy, Play Therapy and Rational Emotive Behaviour Therapy, amongst others, are common. Some models have gained ground such as Family, Person Centred and Play Therapy due to urbanization, families experiencing difficulties and many children experiencing challenges after losing loved-ones, and trauma caused by conflict due to chronic diseases, war, or troubled families. Similarly, Gichinga (2007:22) explains that the counseling and psychology introduced in Kenya are replete with western terminologies and need contextualization. Mucherera (2017: Vii) underlines the importance of context saying that DSMV

[4] The acronym A.I.Cs may stand for several things but have the same meaning- It applies to all Christian churches which are started and controlled by Africans (therefore A.I.Cs may refer to: African independent churches, African instituted churches, African initiated churches, and African initiatives in Christianity or African indigenous churches. Some would refer to them as African Christian initiatives). We will use African initiated churches in this study. (See also Chitando 2005:85-110, Chitando *et al.* 2014:7,9)

[5] A.I.C's believe in spirituality, prophecy, spiritual healing and relying on the Holy Spirit's guidance. Certain beliefs and practises that make A.I.Cs distinctive prominent among them are revelation through prophets, faith healing and ritualistic tendencies (Pirirani, 2015:11-13, Kgatle, 2018:1). Anderson (2001:3-12) and Pobee (2002:8107), discuss different types of AICs that include, separatist churches, spiritual or Pentecostal churches, Ethiopian movements, Zionist churches, messianic movements, prophetic movements, apostolic movements, and syncretistic /naturalistic movements, amongst others. Separatist churches broke away from historic churches founded by church missionary society such as Aladura in Nigeria. Spiritual or Pentecostal churches emphasises the Holy Spirit while Ethiopian movement emphasize on the importance of Africans controlling their own affairs in religion and secular. Zionist on the other hand are interested in adaptation of Christian teachings and liturgy to indigenous cosmology and ways of worship. They stress expressive and emotional phenomena and strong fears of witchcraft among Africans (Anderson, 2001:4-8)

(2013) now has a culture specific section which focuses on how certain illnesses can only be diagnosed using certain indigenous methods as context is everything and matters. Masambia (2014:9) points out that counsellors and psychologists in sub-Saharan Africa have been trained to follow major models of psychotherapy in the western countries. The researcher sees that the influence of the helping professions in Africa, particularly the packaging and implementation of counseling using the western frames of reference (western culture and Worldview) is a matter that cannot be ignored. Louw (2008:153) notes that within the African perspective, the human being cannot be understood separate from cultural issues and values. He adds that humans are embedded in culture. Idang (2006:98) states that culture is that multifaceted whole which comprises knowledge, belief, art, morals, law, customs or any other capabilities and habits acquired by man as a member of society (Taylor, 1958).

Similarly, Jariya (2012:62) states that culture is broadly agreed upon as the pervasive and shared beliefs, norms, values, and symbols that guide everyday life transmitted by symbols, stories and rituals often taken-for-granted, an integrated pattern of human knowledge, belief, and behaviour that depends on the capacity for symbolic thought and social learning and the set of shared attitudes, values, goals, and practices that characterize an institution, organization, or group. Western culture tends high for individualism and masculinity and low for power distance, and uncertainty avoidance.

Aziza (2001:31) adds that culture includes everything that makes them dissimilar from any other group of people, for instance their greeting habits, dressing, social norms and taboos, food, songs and dance patterns, rites of passages from birth, through marriage to death, traditional occupations, religious as well as philosophical beliefs. Western culture differs from African culture. On the one hand, African culture is understood by Ezedike (2009:455) to be:

> the sum total of shared attitudinal inclinations and capabilities, art, beliefs, moral codes, and practices that characterize Africans. It can be conceived as a continuous, cumulative reservoir containing both material and non-material elements that are socially transmitted from one generation to another. African culture, therefore, refers to the whole lot of African heritage.

On the other hand, western culture refers to what Jariya (2012:66) refers to as the set of literary, scientific, political, artistic, and philosophical principles which set it apart from other civilizations.

Sow (1980:1) says that in the community system, traditional beliefs are based on principles such as value of the collective interest of the group; the survival of the community, tribe, and the union with nature. More so ‘one cannot exist alone, for personal identity is totally embedded in the

collective existence' (Sow, 1980:1). Community plays an extremely important role in traditional life in Africa (Van Dyk, 2008:210). This is echoed by Abioha (2014:250) saying that a communal theory of person sees the human person as an essentially communal being embedded in a context of social relationships and interdependence, never as an isolated atomic individual.

Asare and Danquah (2017:2), while discussing African belief systems and patients' choice of treatment in Ghana, referred to physical, mental and social systems, said that there is interconnectedness in different dimensions. They added that changes in one dimension inevitably affect changes in the others.

It is also worth noting that sensitivity to African ethnic, cultural and communal approaches to pastoral care and counseling play a significant role in care and support of African people in health and healing. African communities, including faith communities among them, namely African Instituted Churches [A.I.Cs[6]] and African traditional believers apply approaches to care for and support people – different from models such as Person Centered Therapy (PCT), Family system therapies, Behaviour Therapies, Logo Therapy, Play Therapy and Rational Emotive Behaviour Therapy which are common only among the mission-instituted churches and healthcare facilities using western medicine.

Gichinga (2007:16-17) states in her book *Counseling in the African Context* that whatever someone does, especially in African communities, one must never lose sight of what his actions will mean not only to him, but to the entire family and at times, the entire community as well.

Magezi (2006:6-7) and Mwaura (2000:72-119) echo what was said that Africans perceive sickness as personalistic since in the African medical system disease causation is linked to somebody or something either human (people) of supernatural (spirits, ancestors, or God) (Berinyuu, 1998:49-50). Other causations noted by the latter include breaking community taboos, offending God, spirits, witchcraft, evil-eye passion, parents, or offended neighbour. Treatment and healing in African communities would involve traditional resources as observed (Pavlik, Heard, Gicheru, Wangengi, Omolo, Akwa & Valentine, 2017:2):

> When an African fell ill, the first course of action was to discern the cause of the illness or health problem by visiting a traditional healer. The patient and his relatives could also visit traditional soothsayers, mediums, and priests for information on the cause of the ailment. Once they knew the cause of the ailment, they would visit the appropriate traditional expert such as herbalists or doctors.[7]

[6] See footnote 4

[7] for proper treatment.

Treatment differed in the western Medicare that involved the concepts of bacteria, infections, laboratory tests and administration of pills. Magezi (2006:7) points out that the concept *illness* is understood differently in the developed countries where disease is seen as impersonal terms and non-systemic terms. Causes of illness could be linked to cold or bacteria, amongst other non-supernatural factors, unlike the African community's understanding thereof.

Hence any attempts in the care and support of a sick person in African communities take into consideration the 'we consciousness' and the 'emotional inter-dependency', 'collective identity' and 'communal solidarity'. In the world, and particularly in Africa, treatment and healing can be better if people in Africa have a holistic approach to healing that recognizes the spiritual, the emotional, the mental and the physical aspect of a human being (Robbins, 2016.np). Similarly, faith healing church communities or religious movements apply counseling approaches to meet contextual needs for caregiving of their members. As we shall see in this study, A.I.Cs apply their strategies that include the use of the Bible, herbals, believing, advice giving, prophecy, anointing with oil, sacrifices, and prayer, amongst others.

This study focuses on exploring faith healing within the belief systems to point out their implications for pastoral care and pastoral counseling in selected A.I.Cs; thus, Muungano Church of all Nations (M.C.A.N) in Bungoma and the Lost Israelite Church (L.I.C) in Uasin Gishu counties.

1.2.1 Location of study

This study on 'Pastoral care and counseling of people involved with faith healing within M.C.A.N and L.I.C belief systems' was performed among two selected African instituted churches, namely 'The lost Israelite church' (L.I.C) and 'The *Muungano* church of all Nations' (M.C.A.N) located in Chemororoch, in 'Uasin Gishu'[8]and Bukembe in 'Bungoma'[9] Counties in Kenya[10] respectively. The Lost Israelite Church was founded by 'Jehovah'[11] *Wanyonyi* in the year 1960 in former Mt

[8] See appendix 10

[9] See appendix 9

[10] See appendix 8

[11] Jehovah, the Latinization of the Hebrew Yehova (Adonai), the transliteration of (YHWH) is the proper name of God of Israel in the Hebrew Bible in Old Testament. It is one of the names of God in both Judaism and in Christianity. The L.I.C use the name Jehovah to refer to their founder and leader Michael *Wanyonyi* who is referred to in this study as Jehovah

Elgon District with membership of four people before it moved in 1992 (relocated in 2003 officially) to its current established headquarters at Chemororoch Village, Kipsomba Location, Soy Division, Uasin Gishu County. The L.I.C has branches in Nairobi, Bungoma, and Kitale Mt Elgon and in the neighbouring country Uganda. The church was registered by the Kenyan registrar of society's body in Kenya giving the L.I.C the mandate to run its business in 1964. L.I.C has an estimated population of 10,000 followers both in Kenya and Uganda[12]. The later church, M.C.A.N, was founded by *Nabii* (prophet) *Yohana* in the year 1951 at Nandolia Village, Bukembe sub-location, Bukembe Location of Bungoma County. The church comprises family members and friends to the founder *Nabii Yohana*. It is estimated that the population of *Muugano* Church for all Nations is between 200 households to 1,000 people[13]. In the two churches actual active members in Kenya are roughly 200 for M.C.A.N and 350 for L.I.C. A detailed narrative concerning the two churches will be provided in the subsequent chapter.

1.3 Problem Statement

People involved with faith-healing within the belief systems of L.I.C and M.C.A.N search for pastoral care and counseling when faced with life challenges. The ministry of pastoral care and counseling is well-established in churches traditionally started by missionaries (M.I.Cs). However, the emerging African founded churches either have limited formal pastoral care and counseling or completely lack comprehensive formal pastoral care in their ministries. Since traditional Christian congregations have no formal counseling strategies, they often are misunderstood, misdiagnosed; hence fail to adequately meet care needs. These churches do not benefit from the available generic pastoral care and counseling strategies due to their uniqueness in beliefs, values, doctrines and view of health and wellness. Any lack of understanding of their needs and context excludes these churches from adequately benefiting from generic pastoral care and counseling approaches. Therefore, a need exists for studying healing practices, documenting it and developing guidelines to not only clarify and better understand the needs of L.I.C and M.C.A.N, but to also inform any pastoral care and counseling responses to similar needs.

1.3.1 Evidence of deliverance ministries

Wanyonyi. The use of the name Jehovah is not the same as Jehovah, the name of the almighty God used in Judaism and Christianity. In L.I.C, Jehovah Wanyonyi is regarded as both human and immortal, a god who is worshipped and obeyed by followers of L.I.C.

[12] E.B, 2017, Preliminary Interview, 24th August. Chemororoch
[13] J.P, 2017 preliminary Interview. 30th September. Nandolia.

The deliverance ministries diagnose the conditions of people as either mental, physical or distress-related while attributing the cause to spiritual entities that reside in people's bodies and cause harm to their health through despicable activities. The widespread African traditional beliefs in spirits and illness causation have led to increased followers of deliverance ministers – particularly the health and healing ministers. African, including Kenyan churches, of all persuasions, nowadays engage in healing and deliverance, amid their harm, failure, inconclusive nature and being questionable (Mucherera & Lartey, 2017:114-115).

Scanty information found in media have briefly been highlighted on background information on life, ministries, and health struggles of key personalities (founders) of these churches (Chege, 2015; Opicho, 2015; Mutambo, 2015; Ollinga & Tunoi, 2015). On the one hand, Van Saane (2010:411-415) discussed a cultural and psychological approach to evangelical faith healing groups, with interest in Mental health, Religion and Culture.

Shohan-Steiner (2010:111-129) discussed Jews' healings and Medieval Saints' Shrines and questioned the assumption and suggested the possibility that some Jews did approach shrines of the saints and sought their assistance, especially in healing physical disabilities. Sandlana and Mtetwa (2009:119-131) on the other hand explored the contribution of African traditional and religious faith healing practices in the provision of psychological wellbeing among the AmaXhosa of Southern Africa.

In Pakistan, Hingorjo and Ali (2016:77) explored beliefs and experiences concerning faith healing among patients visiting family practice services and said that 'literature review reveals that practice of faith for healing is widely used across the world including Pakistan. Faith healing is a therapy, offered in the shadow of religious and cultural beliefs by adapting traditional ways. Patients using faith healing also visit physicians, and the extent to which our patients are involved in faith healing is not fully known.' African initiated churches in general; Roho churches in western Kenya, Akurino, Israel Nineveh churches, amongst others, have information on their activities and leaders. Mwaura (1999:3) discussed the aspect of power use in African instituted churches and said that charismatic power and healing exercised in A.I.Cs is:

> perhaps the greatest display of power in African instituted churches (particularly those of the prophetic/spirit/Zionist type) is in the ministry of healing. The belief in the efficacy of healing rests on faith in the healer and in his or her ability to communicate with the divine to subdue invisible powers which are alleged to cause disease and other types of misfortune.

Ndung'u (2009:87-104), while discussing persistence of features of traditional healing in the churches in Africa among the Akurino churches in Kenya, also mentioned that 'one of the attractions of new converts from mainline churches to the African Instituted Churches (A.I.Cs) is faith healing. Healing understood in its wider sense as the restoration of the wholeness of life is not new to African communities since they practised it long before the coming of Christianity into their continent.

Further, Ndung'u (1998:94-105) has written more about A.I.Cs in Christian worship, particularly in the Akurino churches of Kenya. Elsewhere Padwick (2003:13-19), while discussing the Spirit, Desire, and the World: Roho Churches of Western Kenya in the Era of Globalization, particularly focused on modernity and the modernization era and touched on the changing trends from kinship to individualism, and the issue of separation of body and mind.

From the above-mentioned studies and from a comprehensive electronic search of the wide range of recommended data bases of North-West University (NWU), the researcher established that some research had been done on faith healing in African initiated churches in Southern Africa and other parts of the world. Consulted searches of extensive research database at the Ferdinand Postma Library of North-West University involved:

- NEXUS database System – dissertations and Theses
- ATLAS – -American Theological Library
- EBSCO HOST – Academic Search Elite Database
- Library Catalogue
- RSAT – Repertory of South African Journal Articles
- SABINET – South African Catalogue publications

Even so, no research exists combining faith healing, belief systems and pastoral care and pastoral counseling approaches in the selected churches of this study. Similarly, very little research has been done on people and their religious practices within the faith healing beliefs in L.I.C and M.C.A.N. Lack of existing research on pastoral care and counseling among people of faith in the Muungano Church of All Nations and the Lost Israelite Church in Bukembe of Bungoma County as well as Chemororoch in Uasin Gishu County, motivated the researcher to study the two churches

which have impacted a large number of people in western Kenya.

In the wide search, this current study observed that faith healing was noted as a worldwide phenomenon, and a great attraction to people from mainline churches to A.I.Cs. Issues of modernity, modernization and globalization and their effects on A.I.Cs were also discussed. Worship in A.I.Cs and persistence of traditional features were also noted. Similarly, power use (or abuse) and their connection to faith healing, especially faith in the leader (healer) among the religious leaders, was also pointed out. Moreover, faith healing and the link to patients who received biomedical care were not left out. Culture, psychology, religion and evangelical mental health and faith healing were also discussed, as well as the African traditional religion, faith healing practices for psychological wellbeing.

However, this study found that nothing has been published on a pastoral care and counseling model to assist pastors and congregations of L.I.C and M.C.A.N in caring and supporting their own members with faith healing tendencies and belief systems.

1.3.2 Motivation for the study

The lack of documented evidence of pastoral care and counseling in L.I.C and M.C.A.N motivated the researcher to undertake this study to describe and document what happens in the pastoral care and counseling practices, and to clarify what specifically needs to be done to meet the needs of people. This research informs how it can be done and proposes a pastoral care and counseling alternative model for L.I.C and M.C.A.N.

This proposed model will not only encourage pastors and congregations to effectively respond to needs, but to also equip them with the needed knowledge and skills and the appropriate Biblical foundations for caring for people with faith healing tendencies within the belief systems of L.I.C and M.C.A.N. The motivation prompted the researcher's need for the inquest into the belief systems, faith healing practices and religious guidelines of L.I.C and M.C.A.N. The researcher also saw the need to examine the teachings and doctrinal positions that guide pastors and congregational responses to the needs of people who are disturbed.

1.4 Aims and Objectives.

1.4.1 Aim of the study

The aim of this research is to investigate healing and care strategies with a view to develop a pastoral care and pastoral counseling model to assist people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

1.4.2 Objectives:

The objectives of this research are:

- To describe faith healing beliefs and healing practices of people among believers of the Lost Israelite Church (L.I.C) (Chemorororch) and the Muungano Church of All Nations (M.C.A.N) (Bukembe). (Descriptive Task).

- To evaluate some models/methods from other disciplines used for counseling people with faith healing and belief systems. (Interpretive task).

- To explore the Biblical perspectives on pastoral care and counseling for people within the faith healing practices. (Normative task).

- To develop a pastoral care/counseling model to indicate how pastors and congregations may be assisted in helping people with faith healing within beliefs and healing practices in L.I.C and M.C.A.N. (Pragmatic task).

1.5 Research Questions

This research is guided by one primary question, but four secondary research questions follow, in line with the four main tasks of Osmer (1.6.1 and 1.6.2 below).

1.5.1 Primary research question

What model of pastoral care and pastoral counseling would assist people involved with faith healing within belief systems in L.I.C and M.C.A.N?

1.5.2 Secondary Research questions

- What are the faith healing beliefs and healing practices of people in L.I.C and M.C.A.N? (Descriptive Task)

- What are some of the models/methods from other disciplines used for caring for and counseling people with faith healing and belief systems? (Interpretive Task)
- What Biblical perspectives on Pastoral care and Counseling are available for caring for people within the faith healing practices? (Normative Task)
- What pastoral care and counseling model would assist the pastors and congregations with faith healing beliefs and healing practices in L.I.C and M.C.A.N? (Pragmatic Task)

1.5.3 Central Theological Argument

A Pastoral care and Pastoral counseling model can enhance care for people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

1.6 Research Methodology

The study was conducted by means of a literature and mixed method empirical study.

1.6.1 Literature review

A library research was conducted in which a major literature comprising works published on faith healing and pastoral care were considered. A literature review is also said to be a comprehensive overview of prior research regarding a specific topic. The overview shows the reader both what is known about a topic, and what is not yet known, thereby setting up the rationale or the need for a new investigation, which is what the actual study to which the literature review is attached seeks to do (Denney, 2015:1). The literature review of this current research covered background knowledge concerning A.I.Cs (in chapter 1), Models (in chapter 3) and Theology and Exegesis (in chapter 4).

1.6.2 Mixed methods Research

The empirical study applied a mixed method research (MMR) approach (Creswell, 2012:22). In MMR, the researcher or team combines elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and corroboration (Johnson & Turner, 2007:123). Creswell and Piano (2007:128) explain that MMR method designs are procedures for collecting, analysing, and mixing both qualitative and qualitative data in a single study or a multiphase series of studies. Osmer (2008:49-50) points out that quantitative research gathers and analyses numeric data to explore the relationships between variables, whereas

qualitative research seeks to understand the actions and practices in which individuals and groups engage in everyday life and the meanings they ascribe to their experience.

Archibald, Radil, Zang and Hanson (2015:222) suggest that the benefits of integration in MMR is its potential for providing synergistic understanding, while attending to the shortcomings of both qualitative and quantitative contributes to the proliferation of research. The researcher starts by collecting the quantitative data followed by qualitative data concurrently and mixes the data through connecting. The rationale of making use of the MMR design is that the researcher can verify quantitative findings during the qualitative interviews.

The quantitative phase of the study involved 50 participants (35 men and 15 women) and was conducted using questionnaires. The questionnaires contained open- and close-ended questions.

After having analysed the quantitative findings, the researcher identified themes that needed further clarification during the qualitative phase. 15 participants, from the sample of 50 who participated in the quantitative study (8 men and 7 women) participated in the qualitative phase, which was done via semi-structured interviews. The identified themes were used as an interview guide. The researcher mailed the questionnaires in sealed envelopes to heads of L.I.C and M.C.A.N churches. Upon delivery, gatekeepers distributed the questionnaires to the identified participants who completed them and, once they were completed, they were placed in sealed envelopes and the respective gatekeepers collected them, sealed the envelopes safely, and mailed them back to the researcher who put them under lock. The completed questionnaires could only be accessed by the researcher and the study supervisor. The researcher thereafter delivered the questionnaires to the NWU Statistics Department.

1.6.3 Historical critical exegesis

The study used a historical critical exegetical method (HCEM) to analyse the selected Biblical text, Mark 5:25-34, in this study (Marshall, 1977:126-138).

1.6.4 Osmer's model of practical theological research

Several Models are presently utilised in practical theological research. These models include, amongst others, EDNA (Woodbridge, 2014:90-116), Browning's Model (Smith, 2011:40-50)and Osmer's Model (2008:4). We will look at a brief overview of EDNA and Browning's models before we discuss Osmer's model in the sections that follow.

1.6.4.1 EDNA model

According to Woodbridge (2014:93-96), the EDNA model of practical theological reflection is grounded on evangelical theology in which the Bible serves as the normative basis and standard for all Christian conduct and church service.

Figure 1-1: The EDNA MODEL

Holcombe (2014) adds that the EDNA model is based on five sola that emerged during the protestant reformation. These are sola scriptura – the Bible alone as source of high authority, Sola Fide-Faith alone- as people are saved through faith only, sola Gratia –as salvation is through God's grace only, sola Christus – as the only saviour and king is Jesus Christ and sola Deo Gloria – Glory to God alone. Smith (2010:10-105) says that the EDNA model, similar to the Osmer model, provides effective guides that can be used in theological interpretations of episodes, situations and contexts. The EDNA model of practical theological Research covers four areas of theological research in practical theology with specific questions and functions as portrayed in table 1.1 below.

Table 1-1: The EDNA model for theological research

AREAS OF RESEARCH	QUESTIONS	FUNCTIONS
Exploratory	What has led to the present situation	Investigation
Descriptive	What is happening	Information
Normative	What should be happening	Interpretation

Action	How should we Respond	Implementation

Adapted from Smith (2010:90-116)

1.6.4.2 Browning's model

Browning's model of practical theology addresses 3 specific areas: the inner core that involves the reflection, action, and reflection of the 3 areas – present experience and praxis of a faith community; the outer envelope which is the inherited narrative and tradition; and the third aspect is the overall dynamic aspect that deals with the reconstruction of experience because inherited interpretations are seen to be breaking down (Smith, 2011:17). This model of Browning is a vision for doing theology as a whole, as he believes that theology is fundamentally practical and must follow a practice-theory-practice design. Browning adds that all theology requires four sub-specialities or sub-movements; thus, Descriptive theology, historical theology, systematic theology, and strategic practical theology. Browning advocates for a hermeneutical approach to theological reflection and a critical correlation methodology.

1.6.5 Motivation for choice of Osmer's model for this study

For this study, we used a model for practical theological interpretation proposed by Osmer (2008:4, 84-85). Through the four tasks of the Osmer model, the researcher was enabled to see the process of theological interpretations as spiral and that these four tasks; the descriptive-empirical, the interpretive, the normative, and the pragmatic task, are all interrelated. This model was chosen for this study because it would give a clearer view of the field of enquiry for this research; it would assist in achieving the objectives of the study. Given that the model is useful for leaders of congregations, this suits the researcher's target population and the model's ability to confront realities, including the contextual realities of L.I.C and M.C.A.N. Another important reason for having chosen Osmer's model is that the model breaks away from compartmentalization (silos mentality) to embrace integration in theological interpretations which is key to this study. Based on four tasks and accompanying functions the Osmer model of practical theological interpretation asks specific questions, namely: 1. What is going on? 2. Why is this going on? 3. What ought to be going on? 4. How might we respond? The four tasks and accompanying functions are demonstrated in the table below:

Table 1-2: Osmer's model – tasks, questions, and functions

TASK	QUESTION	FUNCTION

1. The descriptive-empirical task asks:	'What is going on?'	priestly listening
2. The interpretive task asks:	'Why is it going on?	sagely-wisdom
3. The normative task asks:	'What ought to be going on?	prophetic discernment
4. The pragmatic task asks:	'How might we respond?	servant-leadership

Smith (2010:99-105).

1.6.5.1 Descriptive-empirical task

The four tasks, according to the model developed by Osmer (2008:4), guide this research. The first task of Osmer's model is the 'descriptive-empirical' task which poses the question: 'What is going on?' Practical theological interpretation involves gathering information to better understand particular episodes, situations, or contexts (Osmer, 2011:2; Osmer, 2008:4). This enabled the researcher to gather information from leaders of the two congregations M.C.A.N and L.I.C to establish the contextual reality.

1.6.5.2 Interpretive Task

The second task in Osmer's Model, 'interpretive task', attempts to answer the question: 'Why is this going on? This question is important in practical theological research according to Osmer (2011:2, 2008:4), since it assists in entering into a dialogue with the social sciences to interpret and explain why certain actions and patterns related to healing and religious practices are taking place in the L.I.C and M.C.A.N churches under study.

1.6.5.3 The Normative Task

In practical theological interpretation, the third task, responds to the question: 'What ought to be going on?' which raises normative questions from the perspectives of theology, ethics, and other fields (Osmer, 2011:2, Osmer, 2008:4). As a normative task, Smith (2010:112) suggests that Osmer relies on the theological concepts and on theories from other sciences to guide practical theological interpretation. The study therefore identifies theological concepts and themes in passages from Scripture that include themes of faith healing, belief systems and compassionate care. The Bible is used here to introduce theological and Biblical norms and values that can be applied in the strategies of a pastoral model to assist in transforming the existing pastoral care practice by leaders and members of L.I.C and M.C.A.N. This also assisted in highlighting key perspectives and principles of pastoral care and counseling to support pastors and congregations of L.I.C and M.C.A.N in support of disturbed members.

The themes *illness, faith, care, healing, belief, love and affirmation, scarcity, renewal and wholeness, belief, power and access, restoration and community, long-term illness, dreaded disease and impact, and the divine* from Mark 5:25-34 were used in the normative task in chapter 4.

1.6.5.4 The Pragmatic Task

The fourth task in practical theological interpretation is dubbed Pragmatic, which answers the question: 'How might we respond?' (Osmer, 2008:4, 2011:2). This is the main work in chapter 5 of this study. This pragmatic task entailed coming up with an action plan and undertaking specific responses that sought to shape the episode, situation, or context of the L.I.C and M.C.A.N in desirable directions. The study at this stage formulated strategies that would positively influence the pastoral support offered by pastors and leaders of the L.I.C and M.C.A.N congregations to their needy members.

1.7 Study population

The study population for this study included the membership of the Lost Israelites Church of Jehovah *Wanyonyi* (L.I.C) and the *Muungano* Church of All Nations of *Nabii Yohana* (M.C.A.N). The two churches are located in Chemororoch in Uasin Gishu and Bukembe location in Bungoma counties, respectively. The population comprised leaders (pastors and church officials) from L.I.C and M.C.A.N churches.

1.7.1 Sampling

The sample was gathered using random and purposive sampling for use in the mixed methods approach in this study. A sample of 50 was identified and used for this study. 50 participants responded to the questionnaires while out of the 50, selected 15 further responded to the semi-structure interviews (qualitative). The researcher employed purposive sampling and field sampling where random sampling was done to cater for the quantitative research strategies used. Confidentiality was observed for those who were willing to participate in the study. Criteria used only targeted members from the L.I.C and M.C.A.N churches.

1.7.2 Sample size

A sample of 50 participants was selected for the quantitative strategy. The sample comprised 35 men and 15 women church leaders. Out of the 50 participants a sample of 15 participants was

drawn for the qualitative part, out of which 8 were men and 7 women from among the leaders of both L.I.C and M.C.A.N churches. The leaders and members selected for the qualitative phase and quantitative phase was representative of the population of the churches. Church leaders included pastors and officials of the churches.

1.8 Data collection

Data collection tools included closed-ended and open-ended questions for the quantitative strategy and the qualitative approach in a questionnaire serving as the interview guide. Data were collected using questionnaires as well as semi-structured interviews.

1.8.1 Data analysis and interpretation

In analysing and interpreting in the mixed methods approach, as indicated by AHRQ (2013:1-3), the study comprised the integration of data during data collection, analysis, and discussion. Analyses were done appropriate to tradition of method; thus quantitative (closed-ended) and qualitative (open-ended). There was an interface of convergence of data and final interpretation at the end.

The researcher worked under guidance of the Statistical Department of NWU using statistical packages for the quantitative and qualitative data for this study.

For the normative task, the researcher used the historical critical framework to read and interpret select Bible texts. As mentioned earlier, the historical exegetical method was used to analyse the selected texts.

Historical criticism is the study of any narrative which purports to convey historical information to determine what happened and is described or alluded to in the passage (Marshal, 1977:126). Krentz (1975:2,6) defines *historical critical method* as a disciplined interrogation of sources to a maximal amount of verified information. He adds that HCM is a process with steps such as:
1. Determining a text; 2. Looking at a literary form of the passage; 3. Exploring the historical situation – Sitz im Leben; 4. Looking at meaning of words for original author and reader (audience); 5. Understanding the passage in the light of total context; and 6. Background context from which it emerged.

1.9 Delimitations and Limitations

1.9.1 Delimitations

The study focused on the two unique religious groups, the L.I.C church of Jehovah *Wanyonyi* and the M.C.A.N of *Nabii Yohana* that were within reach. The researcher has ease of communication with the targeted groups due to familiarity with the language.

1.9.2 Limitations

Given that the churches are in the rural areas, transportation in the all-weather roads was a challenge, because the roads are impassable during the rainy season. Travelling to and from the study location also had cost implications. The researcher utilized the reliable local transport in the study locations that ensured access to the faith groups. The population of the study area has more women than men; hence the researcher intended to have a balanced sample with good representation of all genders. The other challenge faced and addressed by the researcher was the level of education (literacy). The location of study is a rural community served by an all-weather road and is located approximately 50 kilometres away from where the researcher lives. The road is on a swampy stretch that is impassable and expensive during wet seasons, but the area is accessible. The researcher used the local means of transport (*bodaboda*) motorcycles and sourced for funding for the researcher and the research assistant to access the area. The other challenge was the lack of written literature on the churches' practices of pastoral care; therefore, the researcher used people's stories on care and support in both L.I.C and M.C.A.N.

1.10 Ethical Considerations

Ofonime (2012:305) defines research as 'a systematic investigation designed to develop or contribute to generalizable knowledge,' whereas a human subject is a living individual about whom an investigator conducting research obtains data through intervention or interaction or identifiable private information. He further mentions that ethics is basically defined as the study of moral principles. Ofonime (2012:306) adds that in research, ethical considerations need to be given to the different stages of research. At the stage of design, the research studies must be scientifically sound. During subject recruitment, it is important to obtain informed consent, paying particular attention to the vulnerable groups. The principle of respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. Informed consent should contain three elements: information, comprehension

and voluntariness. The research should bejustified based on a favourable risk/benefit assessment. This bears close relation to the principle of beneficence. There should be fair procedures and outcomes in the selection of research subjects. This is a moral requirement from the principle of justice.

This study sought to follow all Research Protocol at NWU before, during and after the period of research. The researcher applied to the NWU Ethics Committee through the Faculty of Theology for approval before commencing with the research. The researcher also sought permission from the leadership of L.I.C and M.C.A.N congregations to carry out the research. Similarly, the researcher not only protected the participants involved in the study through pseudonyms to ensure anonymity and confidentiality but also obtained their willingness to consent before commencing with the study.

1.10.1 Informed Consent

According to Marshal (2006:25), informed consent is universally recognized as a central component of ethical conduct in scientific research. Investigators working with diverse populations throughout the world face myriads of challenges (Marshall, 2006:25). Obtaining informed consent from every single participant involved in health research is an obligatory ethical practice. Informed consent is a process whereby potential participants are genuinely informed about their role, risks, and rights before they are recruited into the study. Additionally, informed consent[14] is a popular and universal benchmark concept and mechanism for addressing ethical issues in clinical or public health research and an important element in conducting research ethically (Pramod, Aryal, Kurmi, Pant, Teilingen & Wasti, 2016:1-2).

The researcher in this study clarified what the research is about, explained why the participant is involved, for instance as a valuable member of the congregation and leader, and communicated that the participant is involved at own will, without coercion. Further the researcher informed participants that they were free to share their views without coercion, or undue influence. Also

[14] Involvement in research should be the voluntary choice of research respondents and should be based on enough information and an adequate understanding of the research, and the consequences of their participation. The researcher must disclose all important information and any likely risks of involvement, especially any issues around what will happen to the data obtained. It is usually expected that informed consent be recorded in writing (as signed consent forms) and be producible by the researcher in the event of an audit up to some years after the research was concluded (Israel, 2013:246-247).

important was to communicate that participant would receive no direct gains, no pay for involvement, but that they would contribute to care strategies of churches.

1.10.2 Avoidance of Harm (Do no Harm) A.O.H

The concept that connotes avoidance of harm[15] (A.O.H) to participants in research is non-Maleficence. Vanclay, Baines, and Taylor (2013:247) explain that A.O.H is a fundamental ethical requirement in research that no harm must come to participants due to their participation in the research. In essence it means that no participant should be exposed to pain or danger during the research (such as in a psychological experiment or medical trial), but also that there must be no adverse consequences to a person because of their participation. This means that ensuring anonymity and/or confidentiality, measures are key. The researcher must do their utmost to protect participants from any harm, and to ensure under the principle of informed consent that the participant is fully apprised of all possible risks from participation. Avoidance of harm, which is on-maleficence stresses prevention of any amount of harm which could be physiological, emotional, social or even economic in nature (Burns & Grove, 2005:1) that could impact a participant. Therefore, the focus is on avoiding harm to participants, and centres on the fact that it is important to prevent any intentional harm or to minimize any aspect of potential harm by refraining from injuring the respondent either physically or psychologically (Akaranga & Makau, 2016:6). The researcher in this study minimised all risks through 'protection of participants' (Hermandez, 2013:1). Anonymity and confidentiality were constantly maintained.

The researcher in this study took into consideration the best interest of the participants as being paramount. The researcher therefore communicated to participants that no risks would be involved since information would be kept confidential, and that no names would be put on the questionnaires. Their responses would be reported anonymously, and the researcher would protect the confidentiality of all the participants. The researcher also communicated in advance that the participant was free to opt out should he/she feel uncomfortable at any time and that nothing would be held against him/her.

1.10.3 Facilities

Research took place at church facilities at L.I.C headquarters at Chemororoch, as well as at M.C.A.N's headquarters at Nandolia in Bukembe.

[15] Dixon and Quirke (2018:12-24).

1.10.4 Benefits for participants – incentives / remunerations

Participation in this study was entirely voluntary as the researcher did not give any form of incentives or reimbursements. Participants gained skills and knowledge and contributed to strategies for care and counseling in their congregations.

1.10.5 Research Risks

Risks to participants in this study were extremely minimal. Information gathered in this research was kept confidential and the names of none of the participants were disclosed. The researcher-maintained confidentiality and privacy of information throughout the research. Gains for participants who joined this study outweighed the risks.

1.10.6 Legal authorization

The researcher sought ethical clearance from NWU and followed NWU Research guidelines after having obtained field authorization from 'L.I.C and M.C.A.N'[16] church leaderships respectively.

1.11 Announcement of study results

A summary of the outcomes of an integrative model for pastors and congregations of A.I.Cs, specifically L.I.C and M.C.A.N, will be communicated through leadership of churches to respective congregations and individual participants who need them.

1.11.1 Monitoring, Management and Storage of Data

Data were collected from church facilities at L.I.C and M.C.A.N and stored under lock by the researcher. Access to the collected data can only be accessed by the researcher and the study promoter. After data analysis and documentation, NWU guidelines were followed to destroy copies of data both in hard and soft copy. Similarly, the total research process, ethical clearance and considerations, data collection and storage were monitored by the study promoter.

1.11.2 Criteria for participant selection

Those invited as participants in this research are valuable members of the L.I.C and M.C.A.N congregations, and/or form part of the leadership whose views contributed to an improved model

[16] Authorization letters in annexures: 3 & 4

for care of people with disturbances/needs. 50 members in total, both men and women, who are leaders, were interviewed.

1.12 Justification for and Contribution of research

1.12.1 Justifications

Beliefs of people impact significantly on attuning their attitudes, understanding and responses they make to health care challenges and choices for the available healthcare options. At the time of conceptualization of this study, there was no documented evidence of any study of beliefs, attitudes, practices and choices of care and healing among members of L.I.C and M.C.A.N. Whereas much has been done on the A.I.Cs elsewhere, no study exists on L.I.C and M.C.A.N faith groups in relation to faith healing beliefs and pastoral care and counseling models, which makes this study very pivotal.

1.12.2 Contributions of the study

This study is not only timely, since it gave room for gaining insights into narratives of care and counseling of select faith communities but will assist us and influence other churches that have similar needs.

Both L.I.C and M.C.A.N are unique churches in their faith beliefs and healing practices among the AICs in western Kenya. They afforded us the opportunity of understanding L.I.C and M.C.A.N, and other churches build on the same understanding and shared context. Since the two churches relate to many other A.I.Cs in western Kenya, and elsewhere in the world, documentation of their experiences will help inform, relate and respond to care needs of others. Narratives of care from the two churches will inform pastoral caregivers to appropriate pastoral care and counseling for holistic care in AICs.

People involved with faith healing within belief systems of AICs and particularly L.I.C and M.C.A.N need pastoral care and pastoral counseling to cope or manage challenges they face. Results of this study will show the gaps that exist in common pastoral care and pastoral counseling as this relates Pastoral care and counseling strategies to people involved with faith healing within

belief systems of L.I.C and M.C.A.N. This study will contribute to the sharing of Biblical principles and values of pastoral care and pastoral counseling strategies that will guide select faith groups who equally need access to competent pastoral care and pastoral counseling that promote holistic health.

Undertaking this study will greatly contribute to knowledge that will be a great resource for understanding how faith healing is linked to belief systems, clarification of counseling needs of A.I.Cs adherents from other Africa instituted churches, but most importantly the L.I.C and M.C.A.N's frames of reference. The study will also assist in identifying relevant resources and pastoral counseling strategies needed in meeting specific needs for holistic healing and wellness among Christian members in other A.I.Cs. Similarly, this study will also assist in improving the quality of practice among pastoral counsellors serving similar faith groups in African communities at grass roots level.

Furthermore, this study will assist the pastoral counsellors and faith leaders in being more sensitive to the needs of adherents in faith groups with faith healing beliefs, and to take seriously, relevant contexts of their clients for effecting healing and wellness in African communities and churches. The study will further contribute to the ongoing inter-disciplinary approach to caring where theological, social, and psychological dimensions in counseling care will further be appreciated. The completed research work will assist the churches in redefining the counseling and pastoral care approach common in the mainline point of view so that Christians in communities around mainline congregations can be impacted through outreach ministries to enhance their healing and wellbeing. Similarly, the study suggests a model that will be used to meet the needs of people with faith healing beliefs in African Instituted churches.

The study will also go a long way in influencing holistic care among Christian churches through the establishment of competent counseling teams that will develop the capacity of A.I.C's adherents. The model was used to develop guidelines for developing workshops and seminar materials for equipping pastors and Christian caregivers. The researcher contends that, since people with faith healing beliefs are in most cases misunderstood and/or stigmatized, they are bound to suffer due to failure of the existing approaches in counseling in meeting their contextual needs. It is presupposed that for the membership of faith healing communities to be reached and their needs to be met, pastors in their congregations need aid and it is through this study that a competent and relevant pastoral counseling manual or strategy was developed to assist in care-giving among people involved with faith healing within belief systems in L.I.C and M.C.A.N.

1.13 Schematic presentation of Research Process

The research process in this study covered the following primary and secondary research questions, aims and objectives of the study and research methods, as set out in table 1-3 below.

Table 1-3: Schematic presentation of research process

Research Questions	Aims and Objectives	Research Methods
What pastoral care and pastoral counseling model would assist pastors and members of L.I.C and M.C.A.N congregations for the care and counseling of people involved with faith healing beliefs?	The aim of this research is to investigate healing and care strategies to develop a pastoral care and pastoral counseling model to assist pastors and congregations in helping people involved with faith healing within belief systems of L.I.C and M.C.A.N.	Empirical theological assessment of existing practices of care and counseling of people involved with faith healing within belief systems of L.I.C and M.C.A.N among AICs in Kenya.
What are the faith healing beliefs and healing practices of people in L.I.C and M.C.A.N?	To identify faith healing beliefs and healing practices of people among believers of the Lost Israelite Church (L.I.C) (Chemorororch) and the Muungano Church of All Nations (Bukembe) (M.C.A.N). (Descriptive Task)	An investigation of lived experiences of members of L.I.C and M.C.A.N in search of care and support
What are some of the models/ methods from other disciplines used for counseling people with faith healing and belief systems?	To identify and evaluate some models/methods from other disciplines used for counseling people with faith healing and belief systems. (Interpretive task)	Explore, evaluate, assess, and learn the relevance of the interdisciplinary models of care and counseling.
What Biblical perspectives on Pastoral care and Counseling are available for people within the faith healing practices?	To establish Biblical perspectives on pastoral care and counseling for people within the faith healing practices. (Normative task)	In-depth study of Biblical text to determine model perspectives and principles governing pastoral care and pastoral counseling for people in churches
What pastoral counseling model would help the pastors and congregations with faith healing beliefs and healing practices in L.I.C and M.C.A.N?	To develop a pastoral counseling model to show how pastors and congregations may be assisted in helping people with faith healing beliefs and healing practices in L.I.C and M.C.A.N. (Pragmatic task)	Undertake a pragmatic task of practical theological research by looking at report of lived experiences in L.I.C and M.C.A.N and linking it to the Biblical lessons from principles and perspectives governing pastoral care to influence the formulation of guidelines and tools needed by caregivers in L.I.C and M.C.A.N

1.13.1 Proposed structure of study:

Chapter 1. Introduction, Problem statement and background to the study

Chapter 2. Current situation of care and healing practices among L.I.C and M.C.A.N

Chapter 3. The Role of Interdisciplinary Models in care, counseling and healing

Chapter 4. Biblical principles and perspectives on pastoral care for faith healing within belief systems

Chapter 5. An integrated alternative Pastoral care and counseling Model founded on Biblical principles.

Chapter 6. Conclusion, recommendations, and summary of the study

CHAPTER 2: CURRENT SITUATION OF CARE AND HEALING PRACTICES IN L.I.C AND M.C.A.N CHURCHES IN KENYA (DESCRIPTIVE-EMPIRICAL TASK)

2.1 Introduction

This chapter followed the first of Osmer's four tasks in the model of practical theological research – the descriptive-empirical. The researcher in this empirical study followed the mixed method research (MMR[17]) approach as developed by Creswell (2012:1-54), according to which the researcher combined quantitative and qualitative studies to gain the breadth and depth of understanding and corroboration (Johnson & Turner, 2007:123). This descriptive empirical task entailed the background of the faith communities, their faith backgrounds, common life issues that members of the faith communities bring to the congregations and ways the select congregations care and support people faced with challenges.

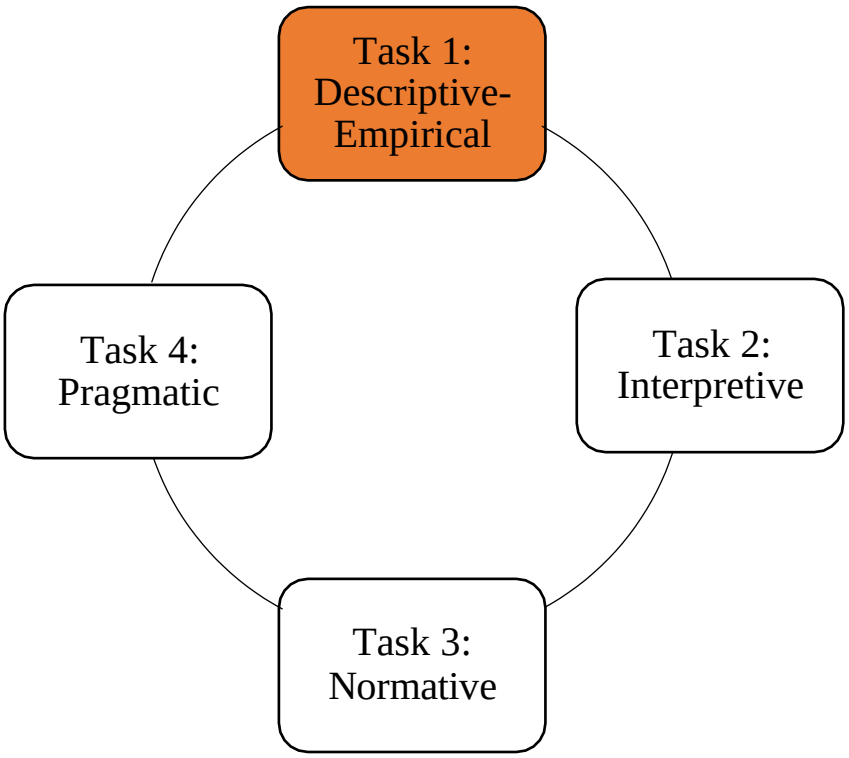

Figure 2-1: Descriptive -Empirical Task Adopted from Osmer (2008:4)

[17] According to Wisdom, J and Creswell J.W (2013:1), The term 'mixed methods' refers to an emergent methodology of research that advances the systematic integration, or 'mixing,' of quantitative and qualitative data within a single investigation or sustained program of inquiry. The basic premise of this methodology is that such integration permits a more complete and synergistic utilization of data than do separate quantitative and qualitative data collection and analysis.

This chapter covers the descriptive empirical research task according to Osmer, which attempts to answer the question: 'What is going on?' This is the first key task in Osmer's model for practical theological interpretation (Osmer, 2008:4). This task is used in this chapter to assist in investigating pastoral care counseling practices in faith healing within the belief systems of the Lost Israelite Church (L.I.C) and *Muungano* Church of All Nations (M.C.A.N) in Chemororoch and Bukembe – Nandolia in Kenya.

The goal of this task is to assist in establishing pastoral care and counseling services and practices in the lived experiences of L.I.C and M.C.A.N churches. This will help us to discern patterns and dynamics in episodes, situations, or contexts of L.I.C and M.C.A.N (Osmer, 2008:4), and further help us to understand the current situation of pastoral care, pastoral counseling and healing practices for people who are challenged with life issues.

2.2 Aim of the study

The aim of this research was to investigate healing and care strategies to develop a pastoral care and pastoral counseling model to help people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

2.3 Research Objective

This chapter had as its objective to describe faith healing beliefs and healing practices of people among believers of the Lost Israelite Church (L.I.C) (Chemororoch) and the Muungano Church of All Nations (Bukembe) (M.C.A.N).

2.3.1 Chapter research question

The question this chapter sought to answer is: What are the faith healing beliefs and healing practices of people in L.I.C and M.C.A.N? (Descriptive Task).

2.3.2 Chapter logical structure

Chapter two is the Descriptive-Empirical task that sought to investigate the situation of current faith healing beliefs and heling practices of congregation and caregiving leaders in L.I.C and M.C.A.N churches in Kenya. The chapter outlines chapter aims, objectives, the research methodology, data collection tools, data storage, data interpretation, analysis and presentation. The mixed method of research was employed alongside Osmer's method of practical theological research was used.

Ethical considerations followed the ethical guidelines of NWU throughout the study.

2.4 Research Methodology

As stated in the previous chapter, a mixed methods research (MMR[18]) approach was applied in this study (Creswell, 2012:1-54). The researcher uses combined[19] elements of qualitative and quantitative research approaches to achieve the breadth and depth of study according to Johnson and Turner (2007:123). The MMR method will be used to collect, analyse and mix both qualitative and quantitative methods in a single study according to Creswell and Piano (2007:128). The study began with quantitative followed by qualitative research. Historical critical[20] and textual critical method for interpretation of the select text's pericope was also applied. A literature review was done on works on faith healing in AICs' belief systems.

The researcher used the questionnaires for the quantitative aspect of this research while conducting interviews using the developed semi-structured interviews. The researcher sought to investigate care and healing strategies in L.I.C and M.C.A.N in a bid to understand the unique care practices, resources, skills, strengths, and weaknesses, particularly in the two congregations.

2.4.1 Data collection tools

The researcher utilized questionnaires and semi-structured interviews to collect data from quantitative and qualitative studies respectively. Both 'closed-ended and open-ended'[21] questions for the quantitative strategy and open-ended questions for the qualitative approach in a questionnaire were utilised.

2.4.2 Data storage and analysis

As stated in the previous chapter, collected data were kept safe in lockable drawers and accessed only by the researcher and the research promoter. The researcher used statistical packages for the

[18] It has been observed that 'use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone. This results in better understanding because mixed methods offer strengths that offset the weaknesses of separately applied quantitative and qualitative research methods.' (Creswell, 2006:19).

[19] Creswell & Piano (2007:128) have discussed in detail on how in this type of research, procedures for collecting, analysing, and mixing both qualitative and qualitative data are important and utilized.

[20] These authors have dealt at with more explanations and use of Historical critical method at length; Marshal, I. H. 1977. Historical Criticism. New Testament Interpretation: Essay on principles and methods. The Paternoster Press. PBK.ISBN: 085364421. Pp 126-138, Hayes, J.H & Hollladay CR. (1982:30-66), Krentz, E. (1975:1-73), Ellis, E.E. (1992:83-142).

[21] Creswell, 2006:7.

quantitative and qualitative data for this study provided by the Statistics Department of NWU. The process entailed what is referred to by Baden and Major as transcription of the field notes (data), data coding, data categorizing, data converting and creating (2013:419). Osmer (2008:49-50) points out that the researcher analyses numeric data in the quantitative study to explore the relationships between variables, whereas in the qualitative study, the researcher did thematic analysis of the qualitative data that emerged from the survey questions to determine the common themes, major themes or variant ideas from participants.

The researcher sought to understand the actions and practices in which individuals and groups engage in everyday life and the meanings they ascribe to their experiences.

2.4.3 Description of research participants

Criterion used for selection was that participants had to be Kenyan men and women members of congregations in L.I.C /M.C.A.N receiving care, or leaders involved in giving the actual pastoral care to people facing challenges. In total, the study had 35 participants: 20 participants for the quantitative study and 15 for the qualitative study.

2.4.4 Ethical considerations[22]

The researcher protected all participants willing to participate in this study by using non-maleficence and beneficence in the entire research process. Participation was voluntary, and participants were free to opt out whenever they felt uncomfortable. The researcher also ensured officially signed 'informed consent'[23] in written permission[24] from participants of this research was secured. Approvals from the leadership of L.I.C[25] and M.C.A.N[26] were sought before commencement of the study. Similarly, NWU protocol for human research was followed, and the study only commenced once the approval from the scientific research committee had been secured.

[22] Ofonime, (2012:306).

[23] Informed consent is universally recognized as a central component of ethical conduct in scientific research Marsha (2006:25). Informed consent is a process whereby potential participants are genuinely informed about their role, risks and rights before they are recruited into the study. Additionally, informed consent is a popular and universal benchmark concept and mechanism for addressing ethical issues in clinical or public health research and important element in conducting research ethically (Regmi, Aryal, Kum & Pant (2016:1-2).

[24] See appendix 6.

[25] See appendix 4.

[26] See appendix 3.

2.5 Situational analysis of AICs and healing experiences

In Kenya and many parts of Africa both in rural and urban areas, there is a growing number of African instituted churches majoring on healing ministries. Healing ministries are synonymous with Africa initiated or Pentecostal churches in their understanding of health, healing, and diseases in Africa (Mwaura, 2013:415-419). Further, Mwaura[27] echoes the sentiments by observing that in Africa and elsewhere, there is the witnessing of popularity of healing ministries in Pentecostal churches, charismatic movements, Africa independent churches and traditional healing practices. She adds that the healing determines the African understanding of health and diseases. Furthermore, in African understanding, healing is holistic in the sense that it incorporates the spiritual, mystical and physical aspects, amongst others. This is underscored in the article 'The church's Healing Ministry' by the Appiah-kubi (1979). Mwaura (1994:63) added that the church through her healing ministry must also emphasize the mystical, spiritual and physical understanding of health and diseases.

On the other hand, healing in Mission Instituted Churches (M.I.Cs) which is informed largely by the home mission's influenced by colonizers' approach to health and healing, embraced the biomedical approach to health and healing. Early missionaries who founded Mission Instituted Churches (M.I.Cs) followed an approach[28] to social ministry that enabled missionaries in Africa to establish 'mission hospitals'[29] to add on schools and mission centres (churches) for spreading the gospel. This is echoed by Chukwudi (2013:255) who says that through their social mission, missionaries enabled the introduction of Western style Medicare. The institutions they set up, such as schools and hospitals, not only served to introduce western institutional models but also enabled the generation of new professionals such as teachers, medical doctors and nurses.

The health workers in early mission hospitals followed the western approach to health issues. These hospitals were equipped with western medical equipment for assessment of health. The hospitals were also equipped with western scientific medicines[30]. The health facilities with support

[27] 1994:63.

[28] Gichinga, (2007:18) notes that three major concerns of early missionaries were to establish a church, a hospital and a school and a bible school on their mission stations. She adds that the tripartite missionary areas were funded by colonial governments up to the time of independence.

[29] Mission hospitals refers to the hospitals established by Christian missionaries from the late nineteenth century to the present, as well as hospitals established by Africans Christians as part of the legacy of Christian missions in Africa.

[30] Hastings and Forster in AMA journal of Ethics (2006:1) indicate that in 1896 Albert Cook founded Mengo Hospital in Uganda and was also credited with bringing scientific medicine to Uganda, see also Sundkler and Steed (2004:675).

of European mother missions engaged medical personnel (doctors and nurses) in the mission hospitals in several mission fields in Africa who took care of the health needs of the missionaries and the 'natives'[31].

Mwaura (1994:69) says that many Christians in Africa upheld piety as given to them in the missionary enterprises during important/critical stages of life (birth, initiation, marriage, death, incurable sickness, and suffering) and other anxieties in life. It was however observed that the healing of evangelical missions did not have a holistic impact as it was directed at different parts of the same person, (something that) is non-existent in Africa Worldview. For instance, in the 19th Century, like other mission fields in Kenya, there was a paradigm shift from the traditional medical care to western medical care at Maseno Mission hospital, founded by Anglican missionaries who came from England and settled in Maseno in 1906. Pavlik *et al.* (2017:2) noted that during this period, medical practices from developed countries, doctors and medical institutions were introduced.

Henceforth, Africans started attending medical institutions such as Maseno Mission Hospital for the treatment of some ailments but did not cut off their links to community traditional health practitioners. According to Magezi (2006:6) disease causation in Africa, explained by Mwaura (2000:72-79), that in Africa, illness often is attributed to breaking of taboos, offending God and/or ancestral spirits; witchcraft, sorcery, evil-eye passion by an evil spirit and a curse from parents or from an offended neighbour. Therefore, for one to heal, when seeking a cure, one does not only rely on medication (herbs, injections and tablets); this cure also includes mystical and spiritual remedies. Africans often visited western health institutions for attention to some ailments, and also used traditional African medicine men for attention to others. Magezi (2006:6-7) further explains illness causations:

> Apart from witches and sorcerers who predominantly have negative associations, all the other causes of illness result from breaking the equilibrium, which means one brings upon him/herself illness by breaking the balance. Therefore, when people are ill, they consult diviners and *sangomas (Nyanga*), who in turn advise them on the right sacrifices and initiations to appease the ancestors or spirits, thereby restoring the balance.

[31] Pavlik, (2017) reported that missionaries gave free medical services to local people for common ailments as well as complicated diseases such as heart disease in the westernized medical mission hospital of Maseno. https://macleki.org/stories/maseno-mission-hospital/ accessed on 5th August 2018.

Sundkler and Steed (2004:675) observed that many Africans felt that the Western medical approach was inadequate and limited, for it had overlooked the role of the supernatural world, due to fragmentation of the human being. Caregivers of western medicine did not see that there were two kinds of illness, the ordinary diseases including western diseases, and also a wide field of black illnesses, *ukufa kwabantu* (in Zulu), where the white medicine and approach must fail and where only traditional practices could prevail. Here herbal medicine and divination was sought to bring about wholeness. This is echoed by Gichinga (2007:18) who says missionaries who came to Africa in 18th Century '…brought with them their theology and systems of healing'. She however adds that the western style interventions failed to meet the needs of care-seekers and led to what Chepkwony (2006:645) referred to as secret consultation and practice of traditional healers by government civil servants and church members. Elsewhere, Sundkler and Steed (2004:677) state that traditional healers are what is referred to as 'tradipractioners' a term, French in origin, meaning medical practitioners and prophets (who are African), operating according to traditional African experience.

From the information presented above we can already gather that, during the missionary enterprise in Kenya, the Africans were granted the opportunity of receiving treatment at missionary-established churches for their ailments even though traditional medical care was also sought, to address health challenges, perhaps to holistically address African values and philosophy of life. This may have been so due to what was observed, namely that missionaries imported western cultural values and ethos in their work. For instance, we find resonance with what Pawlikova (2007:249-260) said:

> Missionaries, who were themselves products of the Western Christian civilization, carried with them their cultural values and had little doubt about the superiority of their culture. They took from it its conventional features, building churches and schools in the European style and imposing the habits and ethos of the western Christian civilization on their converts. In Christian mission stations, which served sometimes as a refuge for freed slaves, with their own schools, churches, hospitals, stores, and plantations, missionaries exercised a strong superintendence over the moral lives of their converts, banning polygamy, dancing, singing, ancestor-worship and many other customs.

The disconnection between Africa's reality and the missionary enterprise goal led to a schism, that Ayegboyin and Ademola (2011:1-4) located during the period of 1888-1915. This saw the emergence of A.I.Cs in Nigeria, Ghana and South Africa amongst other parts of Africa below the Sahara. This is echoed by Wallace in his article on 'African churches (Mills, 2017:152). Towards the end of the 19th century, splits and breakaways from mission churches to form separate, African-led churches started taking place, which will be referred to as A.I.Cs in this study. A.I.Cs largely emerged due to a number of reasons: restrictions on traditional customs such as circumcision of boys and Female Genital mutilation and Polygamy in Kenya and other parts of Africa. The missionaries held negative perspectives about African practices which made them hold opposing views as was noted by Frescura[32](2015:64-86).

Other factors that led to the rapid sprouting of African churches include the African peoples' passion for a different form of Christianity (purer).[33] They had the desire to indigenize Christianity which was 'overly Europeanized'[34] that did not satisfy their needs. The African freedom in exercising aleadership gifts was restricted by missionary Christianity. Similarly, circumstantial factors such as World War 1 and the 1918 influenza epidemic impact, and the need for prayers and healing that Missionary Christianity failed to provide (Pawlikova, 2007:260). Ositelu (2002:47) echoed this saying that many African instituted churches grew out of a response of the failure of missionaries to relate Christianity to the traditional African view of life.

There are several African spiritual leaders who have founded African churches (Mwaura, 2013:415-419). This became fertile ground for the spread of A.I.Cs in Africa. For instance, in Zimbabwe, Johanne Marange's calling and healing activities, (see Pobee & Ositelu, 1998:31), David Zakayo, who was spirit filled, spoke in tongues and prayed for the sick (see Padwick, 2003:204), Simon Kimbangu, founder of Kimbaguist church who received a vision (see Oduro *et al*., 1984:60-61; West, 1975:45). Similarly, Prophetess Lenshima, founder of Lumpa church in Zambia between 1951 and 1954 had a special message after she had died and came back to life. Her core message was to do away with witchcraft, encourage repentance and healing (Oduro *et*

[32] Their bottomless superstitions, their vile habits and heathen customs - their system of polygamy and witchcraft - their incessant beer-drinks and heathen dances which are attended by unspeakable abominations - these present a terrible barrier to the spread of Christianity and civilization. (2015:357).

[33] For the Africans, they needed Christianity, which was local, relevant to and understood in the African context, hence not so mixed with western practices that could not be understood well.

[34] Anderson, A.H., and Barret, D. 2001.Types of Butterflies: African Independent Churches and European Typologies, Pp.107-108.

al., 1984:62; Bond, 1979:147). Similarly, in West Africa, Turner (1967:27) stated that Oshiletu, founder of Aladura Praying churches, invited people to hear the gospel, receive divine healing and receive cure of all their woes and ailments through faith in God. Furthermore, Turner (1967:27) added that the belief that sickness could be healed through drinking water blessed by Aladura spread, leading to flocking of lepers and people suffering from all manners of disease into towns. This made them build houses near Aladura pulpits, causing pollution of drinking water.

In Kenya, like other parts of Africa, A.I.Cs sprouted, and one of the earliest independent churches is Akurinu church that emerged in Central Kenya among the Kikuyu community in the 1920s. Akurinu emerged with specific aims (Ndungu, 1994:94-96). Another remarkable A.I.C in Kenya is the Africa Israel Nineveh Church (A.I.N.C) located in western Kenya founded by David Zakayo Kivuli in 1942. This and other Kenyan A.I.Cs in western Kenya dating up to 2006 have been discussed by Aoko (1971:20-22) and Padwick (2003:204). Kuhn (2007:1-48) also has produced detailed work on AICs. Gichinga (2007:20-22) remarks that western counseling has grown steadily in Kenya. She however notes that counseling and psychotherapy that was introduced in Kenya are filled with western terminologies (which hardly have local equivalents), and approaches and needs contextualization. This study echoes the above, adding that skills and structured techniques needed in western counseling, the focus of the western psychotherapy (individualistic), need to be improved to make sense in counseling support of people in A.I.Cs with a different belief system.

From the overview expounded above, we can conclude that whereas M.I.Cs embraced the western Worldview and integrated biomedical approach to health in their mission field in Africa, things soon changed after the establishment of A.I.Cs. The A.I.Cs' mission and ministry practice had more than twelve common themes in their messages to their adherents. These thematic areas revolved around evangelism and making new converts, prayer, laying on of hands, prophesy and traditional and faith healing, removal of witchcraft and moral sin, and seeing visions. Similarly, A.I.Cs' themes of Christian revival and teachings, liberating the suffering, addressing barrenness, removal of evil spirits and anti-life forces were common. Last but not least was the theme of release of the oppressed and captives to build a church for the African people. All the afore-mentioned themes formed part of the great calling and mission of A.I.Cs in Africa, and this was largely due to the A.I.Cs' belief systems. This is also linked to what Ayegboyin and Ademola (2011[35]) refer to as the Worldview of the members considered in their beliefs, such as in the forces of evil,

[35] See http://irr.org/african-indigenous-churches-chapter-three accessed in 2018

malevolent spirits, witches, and wizards.

In her search for healing, Africa has been experiencing resistance of biomedical care for vaccination of preventable diseases based on strong religious belief systems, religious group faith healing inclinations, and yet vaccination is an important strategy in pursuing the Millennium Development Goals (M.D.Gs) of reducing high infant mortality in developing countries (WHO, 2003). Even in post 21st century, African governments are yet to achieve M.D.Gs since there are vaccine preventable diseases that are affecting children. In their attempts to address children's preventable diseases, they have faced resistance from a multiple of religious faith groups in Africa. For instance, religious beliefs that led to resistance of medical care practice in Nigeria was led by the Islamic community leaders in 'Kano, Zamfara and Kaduna states[36]. More resistance to western medicine, particularly vaccination of children, was experienced in 1996, and in 2014 in Kenya among the 'Catholic[37] and Kavonokia (Kithinji, 2014) churches respectively.'[38] From the above, we can conclude that linkages exist between faith healing and the beliefs systems among A.I.Cs in respective faith groups such as Islam in Nigeria, Catholic and Kavonokia in Kenya. This becomes an area of investigation on how one can understand faith and belief systems related to health and healing that impact pastoral counseling strategies. This study attempts to investigate the concepts of healing and wellness among the selected African instituted churches to establish the link between faith healing and belief systems, and the impacts thereof on the biomedical approach. It will also explore possible avenues for effective clinical pastoral care and counseling among selected A.I.C.s. This study therefore investigates A.I.Cs so as to ascertain their belief systems with the aim of developing more responsive pastoral counseling approaches that will address their Worldview and promote holistic healing.

2.6 Background on L.I.C and M.C.A.N A.I.Cs

L.I.C is one of the African initiated religious movements that was established during the colonial era in western Kenya under the prophetic leadership of Michael *Wanyonyi.* The L.I.C trace their roots from the Israelite community of the Old Testament and regard themselves as the Israelites

[36] BBC News.2004. Pollio vaccination Boycott spreads. BBC NEWS.24 Fbruaryhttp://news.bbc.co.uk/2/hi/Africa /3517193.stm, News 24.2004. Vaccine Boycott spreads polio. News24.com. 5 October 2018.
ChurchMilitant.2015. Kenya's bishops call for a boycott of vaccines from the West. ChurchMilitant.com, accessed on 20, 04, 2017.

[38] Mena, A.2014. Red Flags in Kenyan vaccine controversy. Catholic News Agency. 13 November.https://www.catholicnewsagency.com/news/red-flags-in-kenyan-vaccine-controversy-demand- answers-38780 accessed 5 October 2017.

that are lost in Kenya. They are guided by the Old Testament and strictly adhere to the laws that Moses gave to the Israelites of old. They observe the purity laws, religious feasts and rituals and

offerings and the 10 commandments. The ministry of healing is very central to L.I.C. At its formation, and even now, people were and are attracted to the L.I.C movement based on *Wanyonyi's* promise of them becoming healed. His strong healing powers and promises of his leadership to heal different diseases for people who were challenged and needed care and complete healing is extremely attractive.

M.C.A.N started off as a prophetic movement by '*Nabii Yohana* V[38]' specializing in the healing ministry that places more emphasis on purely traditional African healing practices. The healing movement is led by a prophet who believes to be the final prophet sent by God to bring his message to the world about warning people to change and with a special message to re-write the canonised Bible adding 30 more books and a new name. The movement is governed by 12 commandments, and a constitution. The head of this movement works with leaders known by the title disciples and prayer warriors who assist in healing and teaching and praying.

2.6.1 The beginnings of the L.I.C

L.I.C was founded by William Michael who will be referred to as Jehovah *Wanyonyi* throughout the study.[39] *Wanyonyi* started his ministry around 1956 in Bungoma. *Wanyonyi* was born in old Bungoma district, now Bungoma county in 1924. After prophesying and healing for some time in Bungoma, he ventured into new places by late 1940's as *Wanyonyi* began a nomadic lifestyle. He later moved up north to Mt Elgon district, a neighbouring district on the border between Kenya and Uganda where it is believed he established a faith community in 1956. In 1960, he had some following in Bungoma district, but started a nomadic life of moving from one area to another with his newly founded movement. He called the faith movement '*Basiraeli babatiba*' (the Lost Israelites). Mt Elgon was instrumental to the movement as it was regarded as the holy mountain of God referred to as *Sayuni*[40]' by the founder and believers in L.I.C. After arriving in Mt Elgon, Wanyonyi spoke to people about his faith and with time, there were many more new converts. The *Barefu* family and some other new converts donated up to 30 acres of land for L.I.C ministry (Mutambo, 2015).

[39] In this study he will also be referred to as god wanyonyi

[40] *Sayuni* is the name for Zion, the name of Mt Zion in the Old Testament. Mt. Elgon is respected and seen as the mountain of God, where religious groups -traditional and religious made reference to.

People drawn to this faith community sold their property and moved to the land on which members lived together as a unique community of believers, emulating the early church example. Those who were healed remained as members of the community while more new converts thronged in and gathered around *Wanyonyi's* residence with gifts for healing. This appeared to form a strong African faith community during colonial rule. For about four years of Jehovah *Wanyonyi's* ministry, the healing powers of the founder worked, and more people were healed. However, in 1960 the powers which *Wanyonyi* used to cure the different types of illnesses failed. This was a huge twist *for Wanyonyi* since healing ministry was the core reason that drew many people to his faith movement, as all those who came had had hope of being healed of all kinds of illnesses through the power of the prophet, Jehovah Wanyonyi. This caused fury and deep frustration to many more people who had sold their property in search of healing (Mutambo, 2015).

Jehovah *Wanyonyi*, founder of L.I.C together with his church were rejected and ejected from Mt Elgon. The community threatened to kill the founder for they were dissatisfied with his failure to perform more healings to many eager members who had camped at his church premise. This reaction from the community and dissatisfied new converts forced L.I.C and its leadership to run for their lives in different directions. Wanyonyi moved to the neighbouring district of Trans-Nzoia, now referred to as Trans Nzoia County. He was soon discovered and was followed by a group of people from Mt Elgon that wanted to kill him. This led to disintegration of the blooming church as everyone had to run for their precious lives. They also had to look for housing since they did not have homes in Trans Nzoia or Uasin Gishu to run to together with their founder Wanyonyi who moved and lived along Kenya Railways land near Chemororoch with his family (wives and children)[41] according to Mutambo.

Wanyonyi later bought land at Chemororoch village in Uasin Gishu where he settled with some of his followers together with their families. Other faithful members also found small pieces of land near Chemororoch, where they bought and settled. Some members of this movement went to Uganda, others retreated to Bungoma, west Pokot, Nairobi and few chose to live with the founder in a place they regarded as the headquarters of the church – the lost Israelite church at Chemororoch village, Kipsomba location in Uasin Gishu County, Kenya (E.B, 2020).

L.I.C is an exclusive denomination whose members stick together, living as a community of faith practising faith in unison. Members abide by the religious rules which affect every member. Much

[41] Mutambo, A. 2015. Nation. The God who fed from his followers. Daily Nation.12 August 2015.Nairobi

reverence is given to the founder of the movement who, though human and living a normal human life, also has religious functions such as healing and saving, and members of L.I.C regard him (*Wanyonyi*) as a deity – Jehovah Wanyonyi incarnate. They believe he is a god who has come down to live with his people. The religious leader, Michael *Wanyonyi*, has denominational officials who work with him. We have the high priest, angels, intercessors, women leaders, prophets, and seers. It is taught in this faith community that salvation comes to those who become members to the eternal family through faithfully following the teachings according to the law of Moses as was taught to the early Israelite community.

2.6.1.1 L.I.C's Socio-economic activities

The L.I.C faith community live in a communal manner and share everything they have. To earn a living, most members of the L.I.C move from farm to farm offering casual labour, where they are paid daily wages. Those who have some skill, for instance painting or masonry, go out to work and return to the community later in the evening. They use the wages to make offerings and meet other community and individual family needs. Since what they make is little, most of them do receive social support from the people they work for because the ideology that is taught is that members of L.I.C are poor children of God (*batambi ba* Jehovah). Hence, they do not live in luxury or accumulate wealth. L.I.C has a population of between 3,500 and 10,000 people[42].

Childbirth is celebrated and a mother follows the Levitical code of staying out of contact with people depending on the gender of the child; depending on whether it is a boy or a girl. If the child is a boy, the mother comes out of seclusion after 33 days, and after 40 days if it is a girl. On the eighth day after birth, a spiritual ritual is held whereby a male child is circumcised as was done in the Israelite community. The child grows under care of parents and spiritual leaders; especially under that of the high priest. Adolescents and young adults are also guided, and abstinence or sexual purity is taught. When young people reach the age to marry, the woman counsellor and High priest guides them to understand their commitment before they can fully enter a marital union. When people die, Levitical code is followed for purity considerations. Handling the dead and contact with such makes the person unclean for seven days (R.M, 2020).

E.B[43] said that conduct and behaviour of all members is stipulated in the guidelines held in high

[42] R.M, Interview, 20 January 2020

[43] E.B, Interview 20 January 2020.

esteem by leaders and members. Members observe sexual purity, the law, social purity (women in menses/birth and mourning death) and respect the no access to the sacred space, such as the house of *Wanyonyi*, the flag/altar and the sword area. No woman in her menses, whether a congregant or visitor, can go near the altar area. Also only authorised men can visit or touch the sacred space. He added that people who come to visit *Wanyonyi* for care and healing bring with them gifts. The idea of secrecy is extremely high, and members observe the rules on disclosure. What is said and done in the community of believers is kept as a secret and no one dares leak out the information, else they face the wrath of Jehovah *Wanyonyi*. An extremely strong commitment and bonding exists in the group, and it is not easy to move out. If someone pulls out of the group, they fear they will not be accepted elsewhere or they may be punished by Jehovah *Wanyonyi. Wanyonyi* is respected by all leaders in the movement and members of congregations. Being the founder, and having both human and divine positions, he holds the senior most position. The high position is depicted in the leadership structure below.

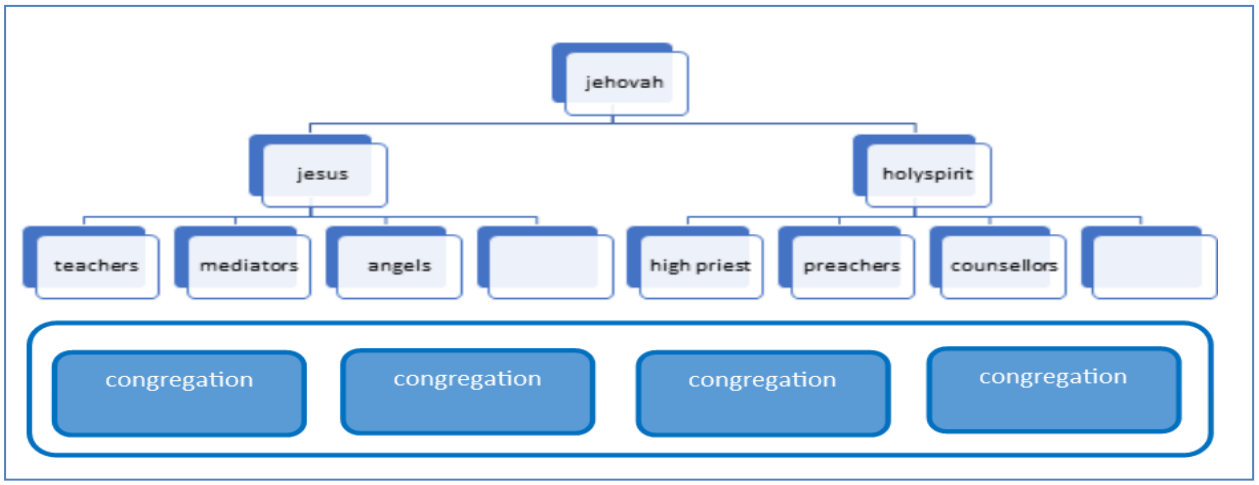

Figure 2-2: Leadership structure of the L.I.C church

(E.B, 20 January 2020).

At the top of the hierarchical leadership is Jehovah *Wanyonyi*. *Wanyonyi* enjoys the position of the overall founding leader as well as a human deity reverenced as Jehovah *Wanyonyi* (god *Wanyonyi*) by all members of The Lost Israelites of Kenya church. *Wanyonyi* is said to be the 'God incarnate'. It is believed that Jehovah came back and lived among his people to meet their needs on earth. Jehovah Wanyonyi has the power to heal all kinds of diseases and forgive the faults of the members. Members of L.I.C believe in the divinity of Jehovah *Wanyonyi* and demonstrated genuine reverence and adoration of this human deity who they give total allegiance by giving their wealth, time and identity, as well as obedience to the guidelines that govern the faith community

members. Jehovah has a special dress code that includes a Red hat, a gown, a stick and a special chair and room where he sits. Jehovah *Wanyonyi* is followed by Jesus Christ who he calls his son. Jehovah waits for the return of his son Jesus so he can give him back the rule over the entire world. They also have the Holy Spirit who completes the trinity and plays an extremely significant role in L.I.C (E.B, 2020).

The high priest who comes immediately after the trinity is held in high esteem because he is the link person between the members of the congregation and the senior religious leaders (Jehovah *Wanyonyi*, Jesus Christ and the Holy Spirit). The high priest receives and prepares people and things brought for different types of offering at the altar. He is the only person who can enter the altar and mention the needs of the person coming to bring animals, food or drinks and oil for offering. He also officiates over all sacrifices and offerings made at the altar (M.B, 2020).

Work Ethic practised in L.I.C affects all believers except the founder Jehovah *Wanyonyi*. He is a great beneficiary and custodian of the guidelines related to work and proceeds of work done by members in the congregation. All believers work in people's farms to earn a living, because they were taught that if people do not work, they should not expect to eat. Hence, they go out on people's farms doing manual jobs of tending the fields to be given food supplies or paid in cash. In the evening or after work, L.I.C believers take the whole amount to '*Wanyonyi* the founder of the movement to be blessed.' This founder gives back some of the money to the person who worked and earned the money but then decides to keep the rest. Worshippers see this (working and bringing money to Jehovah Wanyonyi) as their religious duty and find great spiritual fulfilment in giving their money, their wealth or possessions and food after long days of work to the founder or high priest who would receive it on behalf of Jehovah *Wanyonyi* (E.B, 2020).

Weekly religious practices are performed at each branch, but some of the main religious practices and worship in L.I.C are performed uniformly, and regionally. Members of L.I.C in Uganda, Bungoma, Kitale, Chemororoch have annual or biannual religious events – either at the headquarters in Chemororoch or one of the other L.I.C branches.

M.B (2020) said that adherents of this L.I.C observe the sabbath rule; hence hold their worship services on Saturdays but hold other meetings on Sundays. The worship service involves an intense singing ritual with clapping of hands, beating of the drum, use of the flute, the ring and the tambourine. They congregate outside the open space at the headquarters in Chemororoch and sit, kneel or stand facing the flag, wooden sword and the altar on the western part of Jehovah *Wanyonyi's* compound, which also is their headquarters. The high priest and priestess, and woman

leader counsellor leads the services by reading the bible, reflecting, leading prayers and leading songs. Reading of the Bible, chanting of prayers in unison and singing of songs in vernacular is heard meters away from the place of worship, outside the house of Jehovah *Wanyonyi*. The main day is Saturday. The offering is given any time of the day, depending on when one gets paid salary. It was also a practice for someone to donate one's wife or daughter to offer sexual services to Jehovah *Wanyonyi*. He has dominion or power over women and does what he wishes with them. The ladies that already are marked as Biblical women, for example those with names such as Esther, Ruth have certain powers, which means Jehovah *Wanyonyi* will not use them for sexual satisfaction, but as spiritual helpers designated as angels in the church.

For social and religious control of membership, leaders in this movement reinforce the belief in all *Wanyonyi* says, and that which he passes down to the leaders of the church. The leaders respect and have total allegiance to Jehovah *Wanyonyi*. For social control, the church uses both threat and reward that comes from Jehovah *Wanyonyi* himself. Disobedient members are threatened with punishment. *Wanyonyi* warns members that they would die or suffer immensely, should anyone move out of the movement, share the deep-seated stories or should anyone else do something bad to the movement or its followers. On reward, it is said that obedient members of L.I.C are promised healing of all kinds of diseases, be it short-term or chronic diseases, including HIV and AIDS. Then, due to the promise, people who have suffered for long or have chronic diseases get attracted quickly and join L.I.C, based on the healing declared by Jehovah *Wanyonyi* (J.J, 2020).

Membership to this movement involves going through certain rituals for a new convert to belong. The first one is to denounce one's old self and strong ties to community of birth to belong to this exclusive community. The other key thing is selling of personal properties and getting admitted to the L.I.C community in Chemororoch village to live as a society. The motivation for being founded on the belief that the Lost Israelites are '*batambi ba wele'* (The poor of God) who do not own property outside the communal property. Focus on Communal Care and healing of people with challenges in L.I.C is very important in everyday life of the Lost Israelite church (E.B, 2020).

2.6.2 The M.C.A.N background and Leadership structure

Muungano church of Holy Spirit for all nations (M.C.A.N[44]) is found in Nandolia village, Bukembe, Kanduyi constituency in Bungoma county in western Kenya. The church was

[44] Background information on M.C.A.N was disclosed by Nabii Yohana (V) the founder of church during a preliminary study (Yohana, Interview on 20 January 2020 in Nandolia village, Bukembe).

established by Nabii Yohana (v) whose original names are Ronald Nakalila Wanyama. *Nabii Yohana* (v) was born in 1924. He is married to 39 wives and has in total sired 107 children.

Prophet *Yohana* claims he is the reincarnated John the Baptist who was beheaded. He says that God called and appointed him as the third prophet after Moses and Jesus. *Nabii Yohana* says he received a vision at the age of 8 years and heard God calling him with a big mission for the whole world. His mandate for over 68 years has been to prepare the way for the coming of the messiah. He has written his own bible[45] (unpublished) that comprises 93 books, compared to the Christian Bible that contains 66 books. Similarly, naming[46] of the books in the bible written by *Nabii Yohana* (v) also differs. *Nabii Yohana* (v) has a group of 12 disciples, the majority of whom are men that work with him as pharisees, teachers, preachers, healers, and overseers. The prophet (*Nabii Yohana* v) sees his major ministerial responsibilities to be: preparing the way for the coming of the messiah, prayer, and healing of all people who come with different life challenges, foretell-prophesy to the people what their life holds, heal different types of illnesses, resurrect the dead people, address the social, religious and political issues facing Kenya, advising people on issues and telling them what they need to do, to heal, assess the challenges and give the right intervention (Yohana, 2020).

His leadership structure according to *Nabii Yohana* (v) is directly from God with a mission to save mankind from corruption, homosexuality, and bad governance. See structure 2.3.
Nabii Yohana (V) is the senior leader of the church and is directly under God who communicates with him directly. All care and health decisions are made or communicated to him. He gives spiritual guidance and leadership to the team of disciples who work directly under him. All people needing care must have faith in Nabii's care to receive advice, instructions, herbal, and sacrificial services for healing (E.W, interview, 20 January 2020).

[45] The Bible used by Nabii Yohana, going by the name '*Agano mpya na ya mwisho'* translated as the 'New and final testament' is unpublished. The bible is in the Draft copy, waiting to be published sometime in the future.

[46] Books of the Bible written by *Nabii Yohana* include among others found in the bible. The unique books include--Haggai, Agnes, Immanuel, Mfarisayo Paulo, Peter (*Petro*), *Mfarisayo* Peter, Benson II, *Mfarisayo* Wilson and *Mfarisayo* Geoffrey.

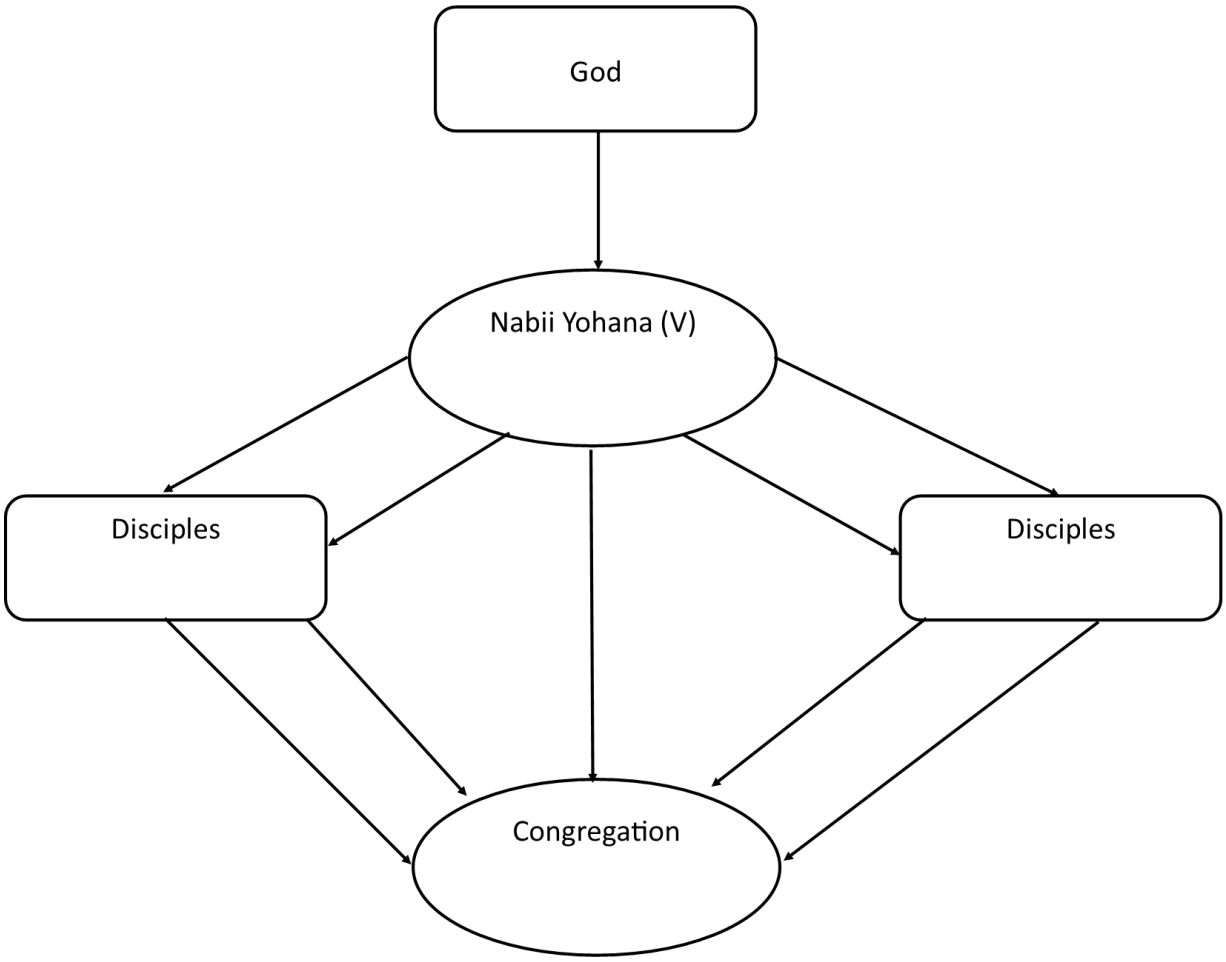

Figure 2.3: M.C.A.N leadership structure

2.6.2.1 Social and religious practices

Nabii Yohana (2020), in a pilot study (preliminary) said that the ministry of healing is very central to M.C.A.N. He added that he serves people who come for healing every day of the week except on Sunday when he goes to church. Nabii confirmed that he has devoted his entire life serving people from the time God called him. Some of the disciples who have been trained as healers assist the prophet in welcoming people who come for healing care. He adds that the healing team (*waponyaji*) in M.C.A.N diagnose the healing needs of patients under the direction of the prophet who gives the final diagnosis and prescription.

Engineer[47] said that depending on the type of challenge one is facing, healers receive gifts that include money, chicken, goat or even cows from those who seek care and healing for it to work. Some people who do not recover from hospital visits are referred to prophet Nabii Yohana (v) by family and friends who have faith in his healing for further investigations and prescriptions. The initial step for healing is removal of shoes and entering the consultation room where the healer(s) receive the person and refer to Nabii Yohana (v) for further diagnosis and prescription. Nabii Yohana (v) has two shrines for his religious functions. One is built at his headquarters in Nandolia and another one in Lwakhakha, one of the towns located on the border between Kenya and Uganda[48].

2.7 Research findings: analysis, presentation, and interpretation

2.7.1 Introduction

This section on research findings falls within two major parts. Part 1 being a presentation of participant demographic data, while part two will be a presentation of L.I.C and M.C.A.N participants' experiences of pastoral care and counseling of people with faith healing within belief systems of L.I.C and M.C.A.N in sections 2.7-2.7.17

The descriptive-empirical task of the study 'Pastoral care and counseling of people involved with faith healing within belief systems of the L.I.C and the M.C.A.N attempted to answer the question: 'What is going on?' The aim of this study was to investigate the pastoral care and pastoral counseling practices in faith healing contexts of people involved within the belief systems of the L.I.C and M.C.A.N of care-seekers and caregivers, God-image in care, and challenges care-seekers experience.

The four objectives that featured in the interview questions and the questionnaires this research attempted to achieve were aligned to Osmer's four tasks, which were:

- To describe faith healing beliefs and healing practices of people among believers of the Lost Israelite church (L.I.C) (Chemorororch) and the Muungano church of all Nations (Bukembe) (M.C.A.N) (Descriptive Task).

[47] Engineer M.M. Preliminary Interview, 5 November 2020.
[48] B. M, Interview, 20 January 2020.

To evaluate some models/methods from other disciplines used for counseling people with faith healing and belief systems (Interpretive task).

- To explore the Biblical perspectives on pastoral care and counseling for people within the faith healing practices (Normative task).

- To develop a pastoral care/counseling model to show how pastors and congregations may be assisted in helping people with faith healing within beliefs and healing practices in L.I.C and M.C.A.N (Pragmatic task).

Through the objectives, the researcher sought to establish knowledge of L.I.C, and of that of M.C.A.N on pastoral care and pastoral counseling practices and services, the belief systems and doctrines, how spiritual resources are used in care, roles and functions and alternative preferred care options.

2.7.1.1 Presentation and analysis of findings

Findings of this study were analysed using the IBM SPSS package for data analysis available at NWU, and thematic analysis of major areas with their sub-themes used by the researcher. The themes together with their sub-themes were based on questions in the semi-structured interview survey questions and the questionnaire to which the participants responded.

2.7.1.2 Description of participants

This section presents the social and demographic traits of the participants. It gives the distribution of respondents based on their gender, marital status, level of education, position, and age. It may seem as if there were more men than women, but in the quantitative study, there were more men and in the qualitative study, more women participants. This demonstrates a balance in the views presented by participants.

Participants in this study (which followed the mixed methods research approach) were a sample of 50 in total. The sample was compiled using random and purposive sampling from a population of 550 active members of L.I.C and M.C.A.N. A sample of 50 was identified and used for this study. The 50 participants participated in the quantitative research while 15 participants out of the 50 took part in both the quantitative and qualitative study. All participants responded to the questionnaire and interviews. They were from the L.I.C church and the M.C.A.N church in Chemororoch and Bukembe in Kenya respectively. This study was an MMR research that

comprised both quantitative and qualitative aspects of research that employed closed-ended questions in a questionnaire and open-ended questions in a semi-structured interview. The average age of participants in this study was 57 years, with a standard deviation of 13.032. This was calculated from participants' ages that varied from the youngest at 29 years and the oldest being 82 years. This means that most of the participants were older than 50 years. M.C.A.N church had more younger participants, and newer members than L.I.C. From among the participants, leaders who were older than some members had slightly more knowledge of the churches and the care given due to their long years of service and involvement. However, some members gave responses on care similar to those given in the churches.

The gender of participants in the study comprised more men at 60% and women at 38%, but one participant decided not to answer the question on gender at 2%. It was imperative to report gender because it determines representation of roles and influences the roles participants play in the congregation, for instance it was noted that men as well as women were leaders at different levels of influence in pastoral care and counseling in the churches; even when we had the men as founders of the congregations.

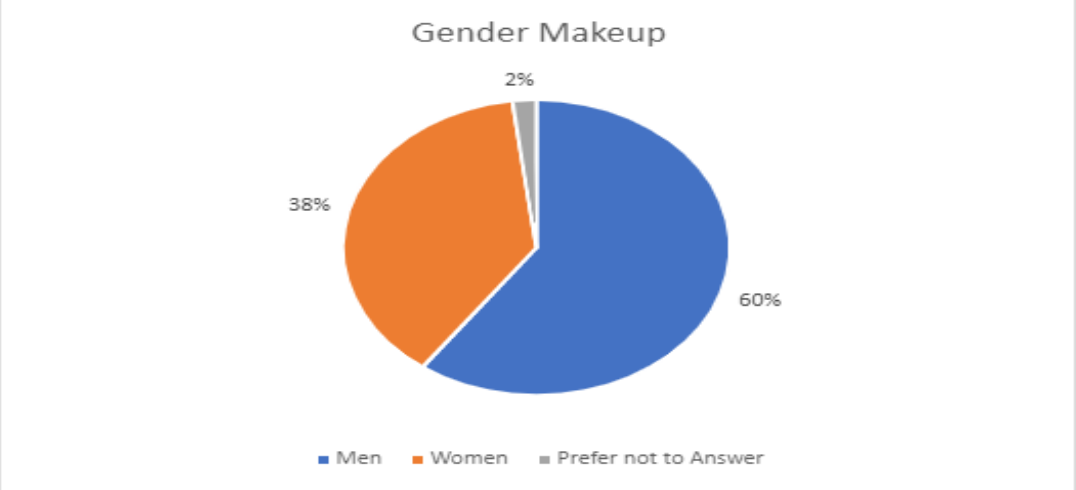

Figure 2-4: Gender representation of participants from L.I.C and M.C.A.N

With regard to the marital status of the 50 participants, 87.6% were married, 2.2% were unmarried while 11.1% were widowed. This explains the role that the family institution plays in the religious life of the churches. It was imperative to record marital status since families determine the size of the household, economic level, and children of members of the church who still play a role in the church communal structure. Besides, marital status could also determine representation of leadership role and level of influence. The data are presented in figure 2.5 below.

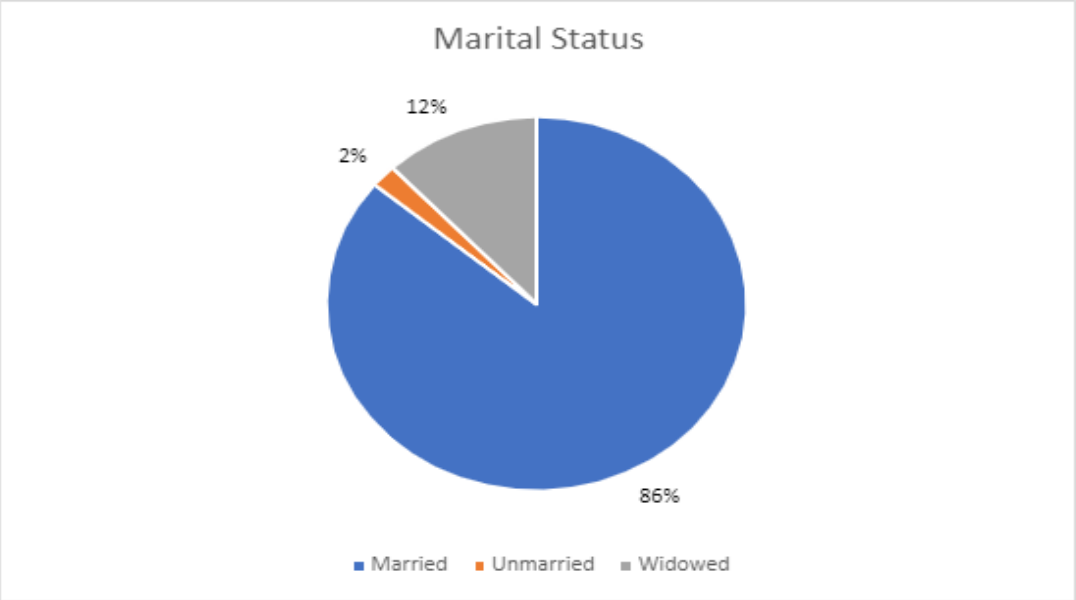

Figure 2-5: Marital status of participants from L.I.C and M.C.A.N

The participants comprised a majority 82.9% with primary school level of education, 4.9% had secondary level education, whereas 12.2% had no formal education. Based on the findings, participants revealed their education level since education determines socio-economic level, attitudes to choice of care, decision making of care options, and control, and adherence to beliefs and healing practices. Education provides skill, opportunities and decision making at a personal level and communal level to fight poverty and make better healthcare option decisions. Data are summarised in figure 2-6 below.

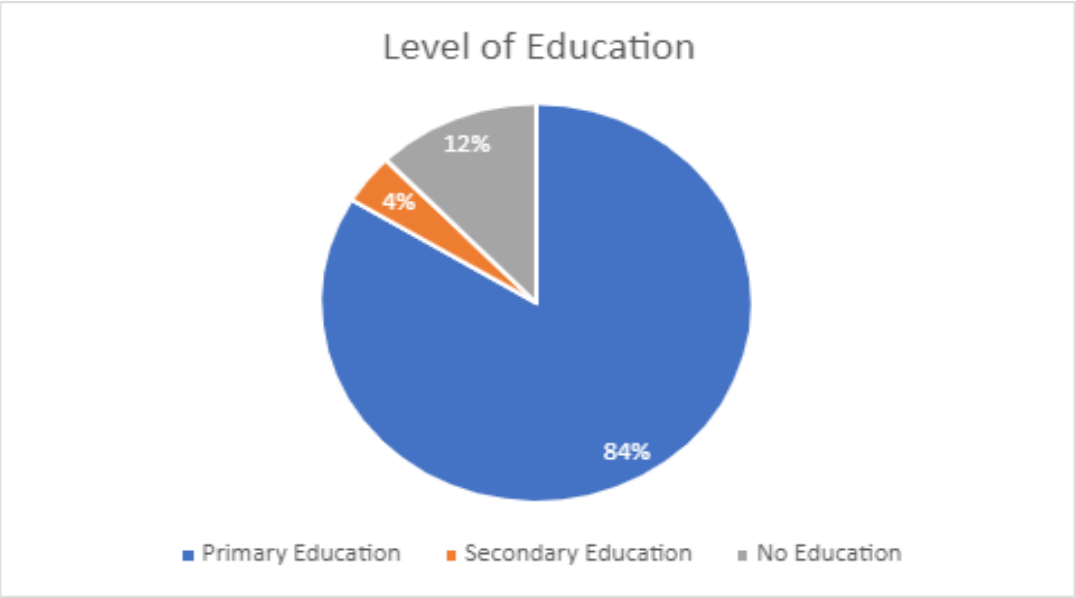

Figure 2-6: Level of education of participants from L.I.C and M.C.A.N

Slightly more than half of the participants were members (52.0%), while the remaining percentage (48.0%) were leaders of congregations. Based on the data, asking participants on their position in the church would provide us with knowledge of their roles and understanding of their involvement in pastoral care and counseling services offered in the congregations. This would also explain the level of influence, and attitudes towards faith and belief systems in the churches and oversight of pastoral care and counseling in L.I.C and M.C.A.N. The summary is given in figure 2-7.

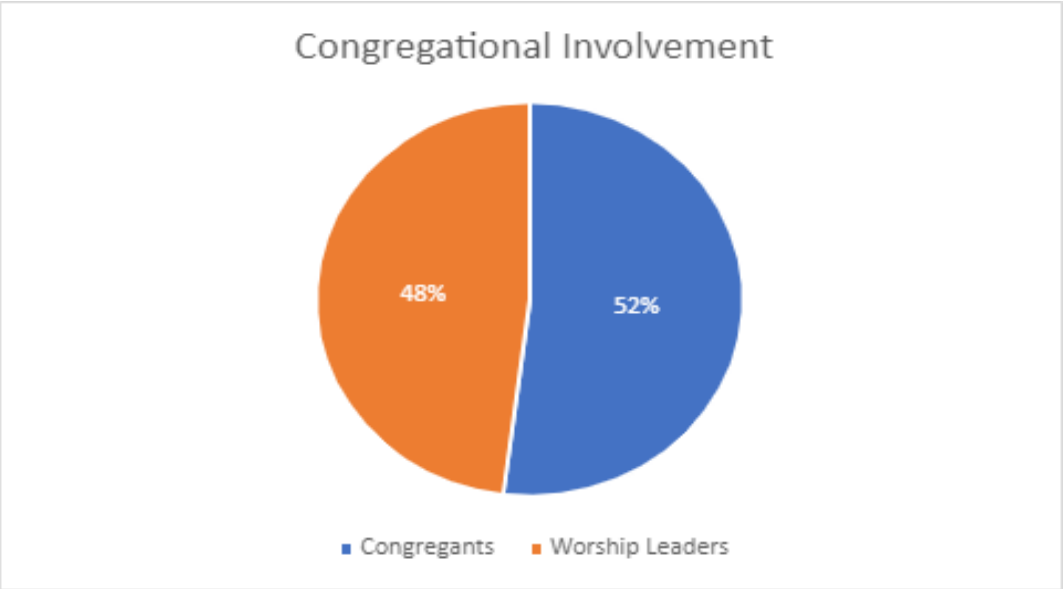

Figure 2-7: Positions of involvement in L.I.C and M.C.A.N churches

2.7.2 Knowledge of pastoral services

From the information supplied, it was evident that all 50 participants had a thorough knowledge of procedures of care and healing, behaviour of people seeking pastoral care, roles of caregivers and care-seekers alike and resources for pastoral care. Participants were knowledgeable about pastoral care services, pastoral care givers, congregational faith, and beliefs and activities concerning pastoral care and counseling in both L.I.C and M.C.A.N. These aspects were important because participants would give information on their knowledge of their congregational, but also alternative pastoral care services, accessible to them. The summary is given in figure 2.8 and the explanation follows below.

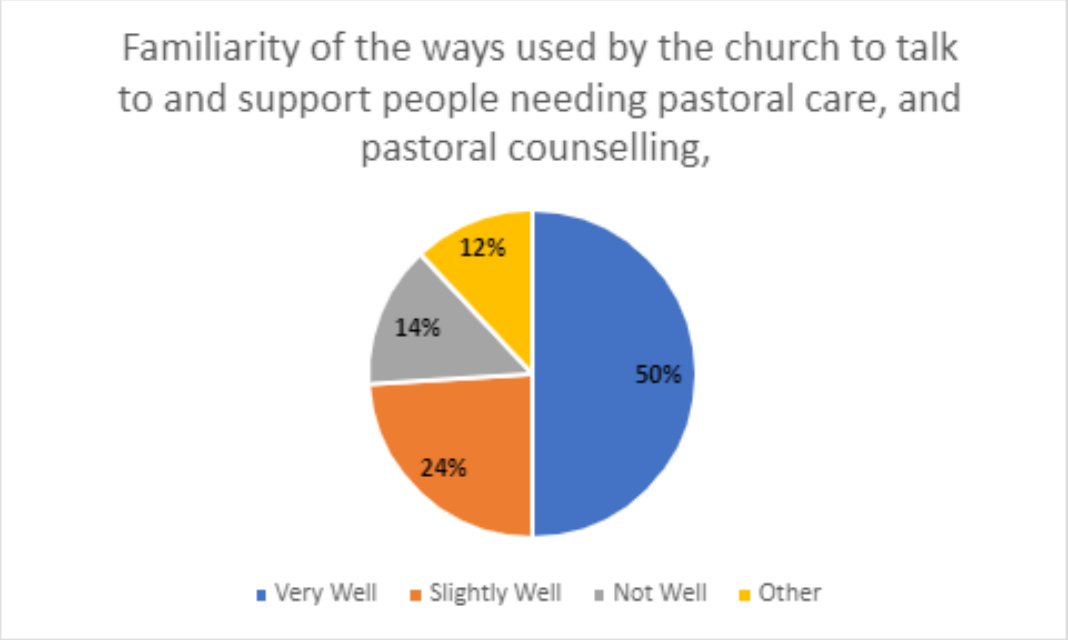

Figure 2-8: Knowledge of pastoral caregivers

Participants indicated that *Nabii* as founder is to be trusted, respected and obeyed as a God appointed prophet with divine power to heal all needs of people according to the new bible and the constitution and the 12 commandments.

Similarly, participants from L.I.C said that Jehovah is 'God incarnate' who has come to be with his people and heal them in their needs. Therefore, Jehovah should be honoured, trusted, and accorded total loyalty as this forms part of the healing requirements in the churches. Furthermore, participants said that they also believe in religious healing rituals administered by religious leaders in their congregations.

In the procedure of care, L.I.C participants on the one hand indicated that care-seekers inform leaders of an issue or visit the church and accept care. Religious leaders receive the care-seekers and talk to them after having listened to their story. Caregivers assess the needs and advise the care-seekers on what should be done to receive the needed care and healing, including bringing gifts and an animal or a bird for sacrifice. Care-seekers lay hands on the head of the sacrificial animal and sit under herbal smoke as caregivers burn candles, incense and flour, and wash or smear them with herbal medicine for healing and protection.

On the other hand, M.C.A.N participants indicated that care-seekers visit the church to see *Nabii* and tell him what is going on. They are received and ushered into a private room where *Nabii*, through supernatural powers, explains what is happening to them. They agree or explain, then

Nabii and healers further assess the hidden needs and describe to the care-seeker what the healing plan is and all that is needed. Diagnosis is done and for healing to commence, prescribed gifts and animals for sacrifices are brought to *Nabii* who takes them to the sanctuary and/or the shrine.

The care services received by respondents in the study include prayers, visitations, ritual care, assessment of needs, holy touch, making sacrifices, intercession, washing, foretelling, anointing, removal of harmful objects or countering strong evil powers, absolution, and reading and interpreting issues through the bible.

Participants also said care-seekers observe silence and secrecy, obedience, loyalty, and faith in healing and present themselves to healers with prescribed items such as money, flour, candles, oil, whisky, and incense (L.I.C); and chicken, goat, or ram of no blemish, and of specified colour (M.C.A.N). They are aware of guidelines and instructions they follow as they receive the care such as keeping secrets of the church, maintaining orderly relationships with people, for instance maintaining purity and keeping silent; thus, respecting the rules concerning medical care and conduct.

2.7.3 Knowledge of caregivers and caregiver roles

Based on the data gained, asking the participants to share their knowledge of caregivers and caregiver tasks would help us to understand participants' knowledge of specific people charged to give pastoral care and counseling, and to gain clarity of the levels and roles caregivers play in care according to the L.I.C and M.C.A.N. This would also explain church structures and how they affect service provision, and the relationship in caregiving. The summary is given in figure 2.9, table 2.1 and the narrative follows below.

2.7.3.1 Knowledge of caregivers

Participants had general knowledge of caregivers as pastors, congregations, overseers and elders. In the qualitative data, specific names of caregivers were commonly used in each church as shown below (figure 2.9 and table 2.1).

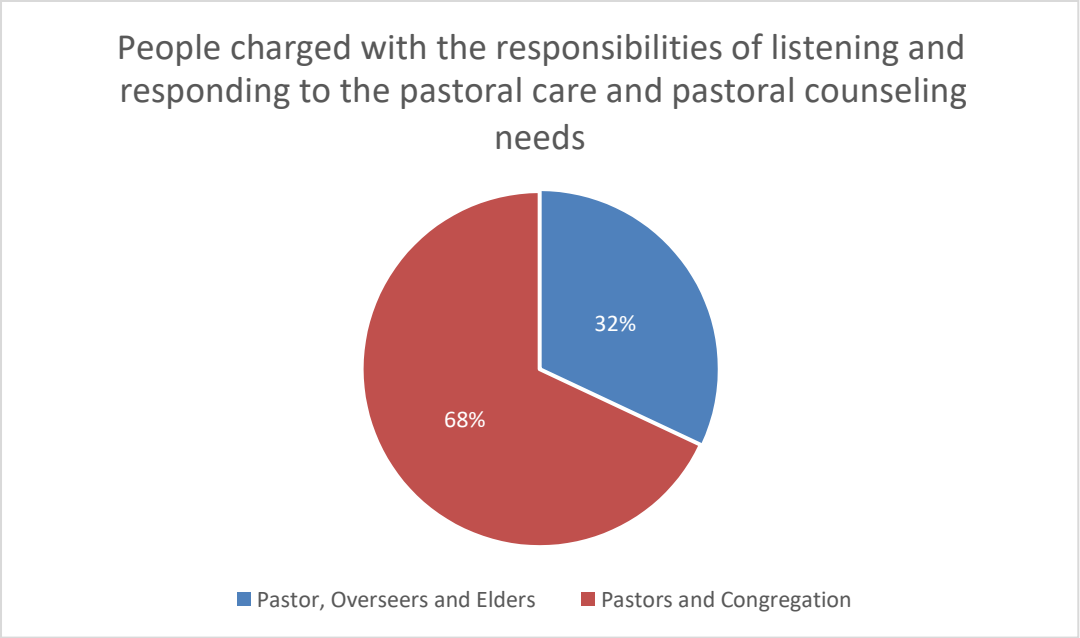

Figure 2-9: Caregivers and roles in L.I.C and M.C.A.N

Most of the participants (68.0%) had knowledge of the caregivers and named pastors and congregations, while 32% said selected overseer and elders as shown in the figure above. However, the qualitative data reveal that the names /titles given to caregivers differ. The titles as used in respective churches, as deduced from the qualitative data, are displayed in the subsequent paragraph.

Jehovah Wanyonyi is the founder and key caregiver in the L.I.C church. He is considered as both human and divine. Jehovah Wanyonyi is married and has a family with wives and children. He shares experiences similar to those of his congregants, but he is more than them because he is God immanent who, according to the teachings of L.I.C, is god who was born as Jehovah Wanyonyi in human community to help his people. Jehovah *Wanyonyi* has powers to heal, forgive and bless his people. Jehovah Wanyonyi is also transcendent as he takes on 'different assignments'[49] away from his people and is in charge of all caregivers and followers in the church. When care-seekers have needs they have trust and faith in Jehovah Wanyonyi. Jehovah Wanyonyi listens to prayers, receives sacrifices, gifts, and offerings, and watches over and protects the members of the congregation. He works closely with the religious team – high priest, *Mama Kanisa*, judges, pharisees, shepherds, angels and teachers. All care-seekers and all religious leaders, respect and

[49]It is believed by his church members that in 2015, Jehovah took on a different assignment away from human beings in the church and community. He still relates with human beings and continues with his caring and blessing and forgiving roles. However, Non-members have diverse opinions some suggesting Jehovah died and went to be with himself, others say he died and was secretly buried by family.

follow orders and are loyal to Jehovah *Wanyonyi* in L.I.C differs from *Nabii* because *Nabii* is an (almighty)appointee of God with given

divine powers to heal.

The high priest is the key officiant of rituals in L.I.C. He is key intercessor during healing at the altar and during visitations. He also determines the type of offering, gift and sacrifice the care-seekers are expected to bring according to the law of Moses. He interprets the law of Moses and applies it to different needs and situations that care-seekers bring to the consultation. The high priest also determines the type of offering according to the law of Moses and gives clear instructions on what to do before offerings and sacrifices are made on behalf of the care-seekers. All ritual care activities and healings are referred to him by *Mama Kanisa*.

Mama Kanisa, which translates to 'church mother', is the respected angel, wife of Jehovah *Wanyonyi* and one who is entrusted with intercession and the interpretation of scripture during healing exercise. *Mama Kanisa* receives care-seekers at the church, but also visits homes of care-seekers who cannot make it to the church. *Mama Kanisa* receives all the gifts brought to Jehovah Wanyonyi.

All women, including wives to Jehovah Wanyonyi are angels. They are involved in the service of the church and are readily available to pray, sing songs, for visitation and to pray in the church.

Mafarisayo, translated as pharisees, are men charged with ensuring that all members of L.I.C follow on a daily basis, the 10 commandments and other laws of Moses in the Levitical code on purity, offerings, sabbath, sacrifices and moral regulations. They teach and translate the guidelines to both young and old people in the church.

Mahakimu, translated as judges, are men charged with the responsibility of solving disputes among conflicting parties in the church and among members of the community and church members. They form part of the advising team.

Balindi, translated as shepherd, are men and women who visit people needing care, and who receive reports, and also make follow-up visits to those who had received assistance from the church. Balindi also take material and food items to those with physical and material needs, and report back to *Mama Kanisa* and the high priest on caregivers in M.C.A.N.

Nabii, translated as prophet, is the founder of and leading caregiver in the M.C.A.N church. Nabii is chief advisor and the one who receives care-seekers, in the church and in the home daily for the healing ministry, apart from Sundays. Nabii assesses the needs of care-seekers, foretells what will happen, diagnoses, and provides the healing plan, including healing instructions, which needs to be followed to the letter. Nabii also gives prescriptions for gifts, animals for sacrifices, offerings, and herbal medicine for use by care-seekers. He determines the number of visits the seekers must make util they are healed. Care-seekers believe in him as being the God-appointed one and have faith in his healing work. Here Nabii has all the powers given him by God to implement the healing ministry together with disciples, prayer warriors, teachers; different from Jehovah *Wanyonyi* who has healing powers, and gives powers to other religious healers in the church.

Disciples comprise 12 members; both men and women who assist Nabii in the daily healing ministry and general care of those in secluded care at the M.C.A.N church. Men are the majority among the disciples. Disciples teach, and also play the role of healers. The women disciples who are healers are also called prayer warriors, seeing that they play the role of intercessory during healing.

Healers – are men and women members of the disciples' team who assist Nabii in the M.C.A.N church. They offer hands-on assistance to people in homes and at the church. They visit, support and pray for the weak care-seekers.

Seers – are community traditional healers who have the supernatural powers to have insight and to foretell the future of a care-seeker who seeks their assistance

Diviners – are traditional religious leaders in community, practising divination. They have the power to locate through supernatural means, something hidden in the eyes of common people. Such people can locate harmful charms of evil objects planted in the homes of care-seekers.

Witchdoctors – are traditional healers that are consulted by care-seekers in the community. They are believed to possess expertise on assessing and treating ailments believed to be caused by witchcraft. They use traditional remedies for healing the care-seekers.

School chaplains oversee the spiritual care of learners, teachers and the community in schools where care-seekers take their children. Chaplains assist with counseling support when care-seekers and their children (learners) face challenges such as lack of fees, sickness or disciplinary matters faced due to absenteeism. They talk to them to encourage them and pray for them when

need be.

Social workers – are found in hospitals and are government officials in government hospitals that do socio-economic assessment of patients and their families.

The qualitative data concerning the caregivers are explicated in table 2.1:

Table 2.1: Caregivers in L.I.C and M.C.A.N

	Caregiver titles	Affiliations	Comments
1	Jehovah Wanyonyi	L.I.C	The founder of L.I.C and is also regarded as god. Listens to needs, understands, cares, blesses, forgives
2	High priest	L.I.C	Official officiant of all rituals in L.I.C. The High priest also identifies and diagnoses. He assesses and determines course of action in care
3	*Mama Kanisa*	L.I.C	Is main intercessor and Bible interpreter during care
4	Shepherds	L.I.C	Caregivers in communities and link care-seekers with religious leaders
5	Pharisees	L.I.C	Men involved in administration and coordination of church activities and care
6	Angels	L.I.C	All women are Angels, and they assist Mama Kanisa in prayers and care and visitation
7	Teachers	L.I.C	Clarify to members the core values and beliefs, and teach faith and practices of the church
8	Judges	L.I.C	Assist the high priest, Mama Kanisa and Jehovah in dispute resolution
9	*Nabii Yohana*	M.C.A.N	He is prophet and founder and main healer. He advises, assesses, and gives care plan to healers for further care
10	Disciples	M.C.A.N	The core team of 12 men and women who work with the prophet teaching faith and values
11	Mediators	M.C.A.N	Work with prophet to assist those in need. Are sent on behalf of prophet to those in need for follow-up
12	Healers	M.C.A.N	Talk to those in need and administer care directly under guidance of prophet
13	Women prayer warriors	M.C.A.N	Intercede for all people in need. Work with prophet and healers to reach those needing care
	God	M.C.A.N	The transcendent deity, believed to be almighty, caring, blessing, forgiving, and loving.

	Caregiver titles	Affiliations	Comments
14	Seers, diviners, witchdoctors	COMMUNITY (Privately consulted by care-seeker)	Community caregivers who assess and see the needs of people in the present and in the future. They foretell the concerns and determine what should be done to prevent it
	School chaplains,		Chaplains do spiritual care and counseling in community schools
	Social workers in hospitals		Social workers in hospitals address social needs and link care-seekers with social services
15	God	M.C.A.N	The Transcendent creator God
16	Jesus	M.C.A.N/L.I.C	The son of Jehovah, The son of God who helps care-seekers

2.7.3.2 Knowledge of Caregiver roles

Participants in both quantitative and qualitative data were aware of the task of caregivers in their respective churches (L.I.C and M.C.A.N). By identifying different tasks, participants share the variety of methods caregivers use to offer care in the care system from the beginning, when there is a call for care, for instance during visitation, ritual care at the altar or shrine, when praying and anointing, until the end when care-seekers are healed. This involves telling the care-seeker that they are healed, or a caregiver's action of calming care-seekers when things become tough or making thanksgiving offering when the care-seeker is healed. From the information given in the quantitative data, the majority of the participants from L.I.C and M.C.A.N identified the following major tasks as portrayed in figure 2.10 below:

From the quantitative data, the following tasks were identified by a significant number of participants: Pray (58.0%) in L.I.C, and a few from M.C.A.N assess needs (48.0%). M.C.A.N refer to hospital (52.0%), L.I.C bless (46.0%) and prescribe care (56.0%).

Other tasks pointed out in the qualitative data involve the use of spiritual resources, spiritual powers, faith healing, solidarity, absolution, announcements, and outreach, as displayed in table 2-2:

Table 2-2: Other Caregiver tasks in L.I.C and M.C.A.N

Function	Caregiver tasks	Church
Use spiritual power	Locate and remove harmful charms, neutralize witchcraft, uncurse, remove evil spirits, protect the people from attacks, chase bad spirits, locate other needs, prevent bad spirits from harming people, distinguish those people with black disease.	M.C.A N
Use spiritual resources and exercises.	March and sing, beat drums and use flutes and rings, Prepare animal for sacrifice, offering on altar, beat drum and play flute, interpret the bible through issues, burn offerings and sacrifices and calm people down.	L.I.C
	Identify the right gifts and offerings.	L.I.C and M.C.A.N
Faith in healing	Encourage faith, remind people to trust Jehovah and God, mediate between Jehovah and people, encourage faith in Jehovah, trust in healing from Jehovah.	L.I.C
	Trust healing as Nabii Yohana was sent by God to heal people	M.C.A.N
Solidarity	Encourage faith for healing, collect support for needy, be with the needy, obey the law and help others to obey too, bring together what they must care for the needy.	L.I.C
	Encourage and support morally, stand with the sick, accept all people in need of healing.	L.I.C and M.C.A.N
Absolution and pronouncements	Pronounce complete healing, discipline disobedient people, inform Mama Kanisa of needs.	L.I.C
	Aware of what will happen and tell on time and pronounce healing.	M.C.A.N
	Define plan for healing.	L.I.C and M.C.A.N
Outreach	Religious leaders identify needs in the homes and pay follow-up visits to people in their homes.	L.I.C

2.7.4 Pastoral response to needs.

Asking participants to mention ways in which their churches responded to pastoral needs was paramount. This enabled caregivers to show how different needs, social, spiritual, physical, material, and psychological needs of members of the churches are attended to, and through what means. Knowing this also helped to ascertain whether the churches do or do not respond, as this impacts the level of satisfaction or lack of it, as well as aspects of wellness or challenges. Based on the data, pastoral needs in L.I.C and M.C.A.N were responded to through three major ways; thus visitation, anointing and prayer as depicted in figure 2.10. However, there are other ways of responding to needs that are common and divergent through which the churches meet the needs of care-seekers as depicted in figure 2.10 below.

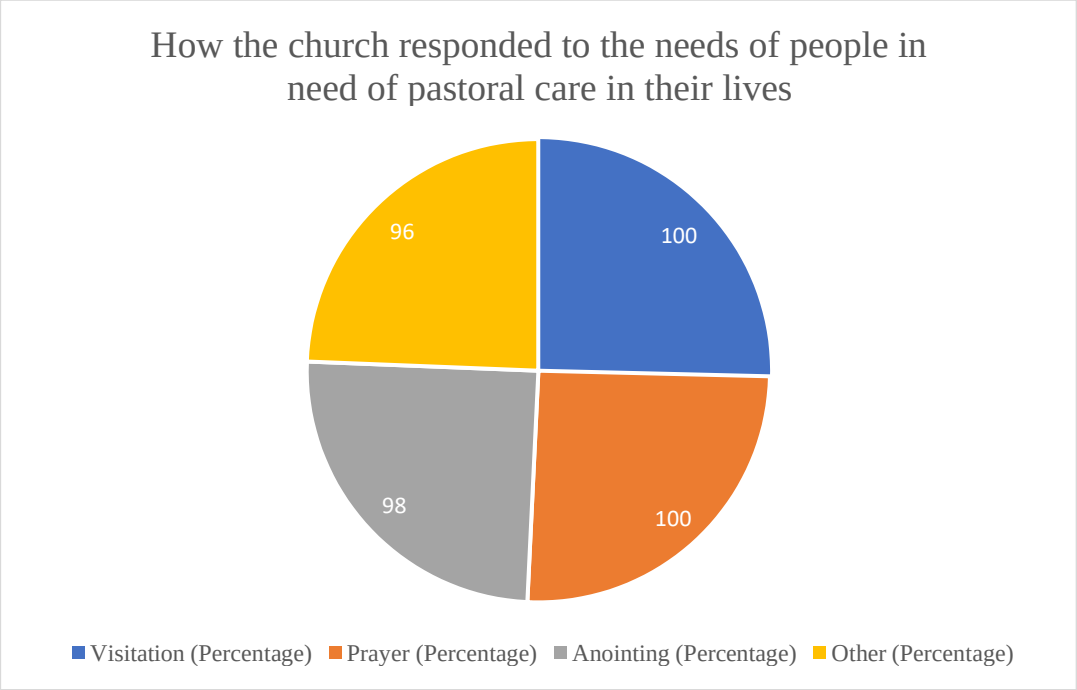

Figure 2-10: Church responses to needs in L.I.C and M.C.A.N

2.7.4.1 M.C.A.N pastoral response

The common things participants reported on are how their churches responded to the needs of people, where visitation scored 100%, prayer at 100%, anointing with holy oil at 98% and other at 96%. The religious caregivers visit the homes of the persons in need, and the care-seekers also visit caregivers or the church for care.

In M.C.A.N the mediators, healers and praying women visit homes of care-seekers. The *Nabii* is the only person who anoints with oil, whereas in M.C.A.N, a significant number of respondents also said caregivers additionally guide care-seekers to visit the shrines for ritual care and offerings. Majority of the respondents added that healing prayers offered by *Nabii* in M.C.A.N enables them to directly receive healing and peace. *Nabii* is assisted by the mediators, praying women warriors and healers in M.C.AN. The praying women warriors offer general prayers for people. A significant number of respondents said holy oil is used by healers to anoint care-seekers to bless, protect and heal them. What also emerged prominently was M.C.A.N church's use of herbal medicine where care-seekers are given oral medicine or charms to be taken and put in food, compounded or placed under a water pot or under the mattress. As part of the healing process, healing instructions, obeying 12 commandments, and respecting the constitution and the new Bible are paramount in the M.C.A.N church.

2.7.4.2 Pastoral response in L.I.C

Prayers are central in any pastoral response in L.I.C. *Mama Kanisa,* shepherds and the high priest pray, but it is the high priest who anoints care-seekers with oil in L.I.C. The high priest, *Mama* K*anisa* and Shepherds offer prayers in L.I.C at different stages in care; thus visitation, reading and interpretation of scripture, intercession, offering and sacrifice times in the church, at the altar and homes of care-seekers.

The high priest prays for the care-seekers as they bring gifts, during offerings, animal sacrifice, and burning on the altar. During intercession, the high priest asks Jehovah to listen and answer prayers of the care-seeker. The high priest also prays on the altar during sacrificial offerings for Jehovah to accept them. Together with the high priest, *Mama Kanisa* prays for the needy after reading and interpreting the scripture.

L.I.C care-seekers, individually, outside church arrangements, seek herbal care from community herbalists. This is occasioned by churches' open policy where care-seekers could receive care or support from hospitals, non-governmental faith-based organizations or care provided from within the communities.

The L.I.C church differs from M.C.A.N in their observance of the laws. M.C.A.N adheres to 12 commandments (reviewed 10 commandments) while L.I.C observes the 10 commandments and adheres to the law of Moses, especially purity codes and moral laws. Also important is keeping the sabbath day and willingness to receive care and participation of care-seekers in care activities.

2.7.5 Healing activities

To ensure healing is given to care-seekers it was important to ask participants to explain the practical religious actions taken by congregations in L.I.C and M.C.A.N when administering care. It was paramount for the participants to identify what healing actions take place when caregivers attend to care-seekers in their respective churches. Participants in L.I.C and M.C.A.N identified commonly used religious activities such as taking gift offerings, making sacrifices, prayer, anointing with oil and prostrating that help them receive healing, as summarised in figure 2.11 below.

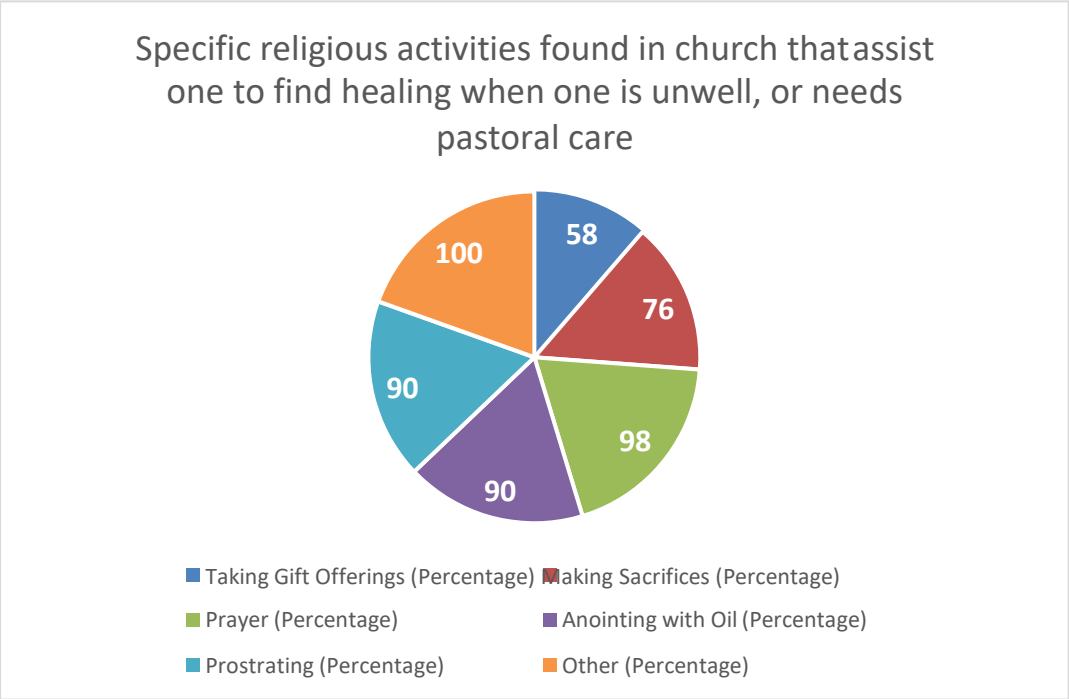

Figure 2-11: Specific religious healing activities in L.I.C and M.C.A.N

2.7.5.1 Healing activities in M.C.A.N and L.I.C

Based on the data described, prominent religious healing activities take place in the two churches. Anointing with holy oil was rated high at (90.0%). This activity is performed by the high priest, *Mama Kanisa* and shepherds (in L.I.C). Disciples, mediators and healers assist *Nabii* during anointment (in M.C.A.N). Taking gifts was rated at (58.0%). This includes, among them, food items, money (both in L.I.C and M.C.A.N), whisky, candles, flour, incense, oil, birds (only in L.I.C) and chicken (only in M.C.A.N). A lamb or goat that is male and without blemish, and of a specified colour is required (in both M.C.A.N and L.I.C).

A significant number indicated that making sacrifices (76.0%) both in L.I.C and M.C.A.N is very instrumental in healing. Sacrifices of a goat or lamb for healing is done by *Nabii* in M.C.A.N. *Nabii* does the sacrificial ritual in the sanctuary and the shrines. The high priest burns the sacrificial lamb's authorized parts on the erected altar in the church compound.

Prayer (98.0%) was a significant activity pointed out by participants. People are prayed for while lying low on the healing mat while bowing down as *Nabii* touches them with the holy leg touch. Prayer is a core activity performed by the praying women warriors and *Nabii* (in M.C.A.N). The majority of participants indicated that prostrating (90.0%) is an important activity in healing. Members of M.C.A.N lie low on the healing mat while bowing down as *Nabii* touches them with the holy leg touch. It was also mentioned that prostrating through kneeling on the ground and praying while touching the ground also is important in L.I.C.

In the L.I.C church, people who assist in the healing in accordance with the L.I.C requirements are *Mama Kanisa*, shepherds and the high priest at different times. Prayers are offered during service on Sabbath day, but prayers are also said while care-seekers touch the head of a sacrificial animal after reading and interpreting the Bible on issues at hand, and when presenting gifts, and offering the sacrificial lamb on the altar.

The following are the majority of the other healing activities in the L.I.C and M.C.A.N churches received from participants who selected 'other' as indicated in sections 2.7.5.2 to 2.7.5.10, and in the summary in table 2.3 below.

2.7.5.2 Other healing activities: qualitative data for L.I.C and M.C.A.N

From the narratives of participants who selected other, and from the qualitative interviews, the following were identified by participants as other healing activities in the L.I.C and M.C.A.N churches.

2.7.5.3 Identifying other needs

The healers in the L.I.C identified the other needs that care-seekers present. These are needs that care-seekers have not mentioned and yet they impact the care-seekers. This differs from the M.C.A.N where the caregivers tell the care-seekers what their needs are, all at once during consultation.

2.7.5.4 Pronouncing healing

Once the process of caregiving has commenced, the high priest and *Mama Kanisa* communicate to the care-seekers when the occurrence of actual full healing takes place. Prayers of thanksgiving are then offered in the L.I.C church. Meanwhile in the M.C.A.N, it is *Nabii* who communicates to the care-seeker when either partial or full healing of care-seekers takes place. This is different from the western models of pastoral care and counseling in which awareness and communication of healing involves both the care-seeker and the caregiver. More so, both the care-seeker and the caregiver participate in determining when the healing has happened.

2.7.5.5 Remove shoes

All M.C.A.N and L.I.C care-seekers remove their shoes when they enter the holy ground. Before entering the house of *Nabii* in the M.C.A.N church, shoes are left at the doorway at the consultation rooms because the rooms are holy and nobody apart from *Nabii* himself can be wearing shoes. Similarly, L.I.C members remove their shoes before entering Jehovah Wanyonyi's room. This is one requirement or practice that is not done in healing in western models of pastoral care and pastoral counseling.

2.7.5.6 No entry – altar space

The altar is a restricted area. The only authorised person who might enter, is the high priest. He is the mediating person between Jehovah Wanyonyi and people in L.I.C. In M.C.A.N, it is only *Nabii* who is authorised to enter the sanctuary and the shrine to administer the care to care-seekers. This could relate with the pastoral caregiver or pastoral counsellor in a therapeutic session and relationship where one caregiver at a time is the only one administering care, although in the western model, provision is made for referrals to other caregivers. In the L.I.C churches only the high priest, as the sole religious caregiver, may enter the altar to pray and make offerings or sacrifices. The only other people who could come near the altar are the care-seekers and the elders who assist the high priest in preparing spiritual resources such as the lamb, oil, incense or oil, or candles needed for ritual care activities on the altar.

2.7.5.7 Determining sacrificial needs for animal offerings and gifts

The High priest in L.I.C is the only religious leader who determines the needs and offerings, or sacrificial spiritual resources, assisted by *Mama Kanisa*. *Nabii* in M.C.A.N is the one who

determines the resources for sacrifice and the offering ritual. With regard to care resources, the two churches differ considerably from those of western caregiving, since western caregiving does not involve animal sacrifice and gift offerings.

2.7.5.8 Giving advice to the care-seeker, respect, and honouring the leaders.

All religious caregivers could give advice to care-seekers in L.I.C and M.C.A.N. However, the final advice is given by the founders of the churches Jehovah *Wanyonyi* high priest, and *Mama Kanisa* in L.I.C. In M.C.A.N, advice is given by *Nabii* during care and by healers during administration of herbal care and during follow-up.

2.7.5.9 Baptism, circumcision of boy children at 8 days, and Money

L.I.C church practises male circumcision, and boy children are circumcised on the 8th day after birth as was done Biblically. Baptism of all people who convert to L.I.C or are born to members of L.I.C is an important practice.

Money forms part of the healing in M.C.A.N and L.I.C. For M.C.A.N, herbal medicine is said to be effective if money is paid, to unlock healing. In L.I.C, care-seekers bring money as an appreciation or gift for the care and healing they receive.

2.7.5.10 Interpretation of the Bible

Mama Kanisa in L.I.C interprets the issues by reading a Bible text, gives meaning and then prays with the care-seeker. Jehovah plays a huge role in healing because he is involved in overall caring, blessing, and forgiving of care-seekers who have made mistakes and are in need of forgiveness.

The qualitative data confirmed the religious healing activities pointed out in the qualitative data, and added a number of other identified healing activities used in L.I.C and M.C.A.N as presented in summary in table 2-3 below:

Table 2-3: Other healing activities in L.I.C and M.C.A.N

Summary of the healing activities			
	L.I.C	**M.C.A.N**	**Comments**
1	Identifying other needs Pronouncing healing,	Foreseeing the future, identifying other needs, locating bad charms, identifying evil forces and people, pronouncing healing,	Foretelling is done by community seers that are visited by care-seekers in L.I.C and M.C.A.N. L.I.C follow the Israelites' Levitical care process; the care-seekers present themselves to care healers who pronounce healing. M.C.A.N use strategies of spiritual power to address evil forces and communicate healing. L.I.C and M.C.A.N differ from Western and Reformed approaches to care. Other than also identifying needs that are not spoken about, Western and Reformed models use structured approaches in their pastoral responses to needs. Furter, the Reformed tradition has the Bible and Triune God as central in care.
2	Remove shoes Not enter altar space when	Seclusion of the person in need of care, exorcising, cleansing, jump over, holy touch, visit shrines	Rituals are unique to a particular church, and M.C.A.N deals with deliverance from evil powers, and visit of sacred sites, while observing purity rules is common within L.I.C
3	Identify sacrificial needs, animal offerings and gifts	Smear with herbal medicine or dung from sacrificial animals, washing with herbs or sitting in herbal smoke, taking oral herbal medicine	L.I.C is keen on offering and sacrificing on altar, while M.C.A.N adds use of herbs for physical care
4	Giving advice to the care-seeker, respect and honour leaders	Advise care-seekers, give instructions on administration of medicine	Advice is given different from western counseling where counseling is done using core conditions
5	Baptism, circumcision of boy children at 8 days,	Charms /bracelet	Rituals of baptism and circumcision are key for members and boys in L.I.C. In M.C.A.N, herbal care is key for all members
6	Take money, read and interpret the issues through the bible	The holy leg touch and prostrating	Both L.I.C and M.C.A.N allow members to take money as gifts. L.I.C use the Bible to interpret issues and communicate what god Wanyonyi has for care- seekers. M.C.A.N on the other hand is centred on respect for the caregiver/prophet, and approaching care involves lying on the holy mat. Instead of touch by hand, M.C.A.N prophet uses the holy leg touch to release healing to the care-seeker.

Summary of the healing activities			
	L.I.C	**M.C.A.N**	**Comments**
7	Caring, blessing, forgiving	Uncursing, exorcising, binding bad spirits, locating evil charms	Caregivers in L.I.C visit and meet the social spiritual and material needs, but the founder, Jehovah *Wanyonyi*, is the one who forgives and blesses care- seekers. In M.C.A.N, caregivers, especially the prophet, has power to deal with evil forces, spirits and evil herbs thrown in people's homes.

2.8 View of God image

The view of the place of God in care for this study was important as it assisted us in understanding participants' expressions of how divine intervention works in their respective churches. Participants explained who the deity is, and the deity's involvement or lack of it. They also explained how the human-divine relationship impacts pastoral care and counseling in L.I.C and M.C.A.N. The presentation of the view that the deity is present is indicative of a higher power from which participants draw strength, communicate to, show obedience to, make allegiance to receive blessings and forgiveness, and receive comfort from, and also exercise dependency in care. Figure 2-12 below gives an account of the 'place of God in care-seekers' lives.

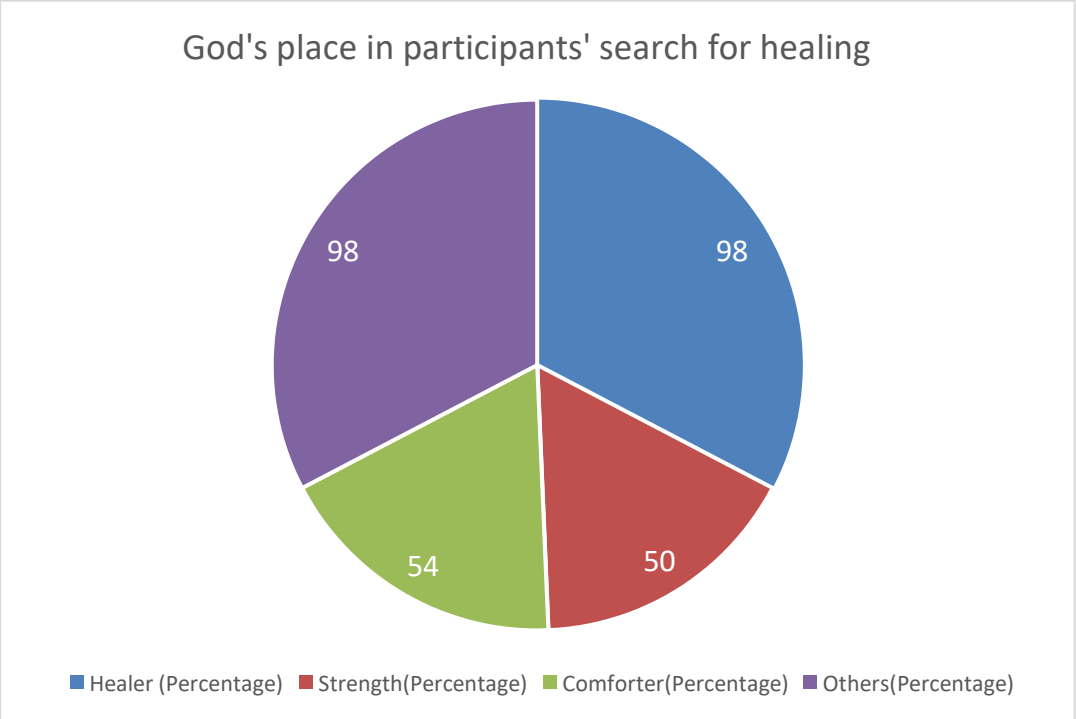

Figure 2-12: God's place in participants' search for healing

Most participants in both L.I.C and M.C.A.N said the almighty God[50] is a healer (98.0%) of all their challenges. God was also significantly seen as strength: 50.0% by the M.C.A.N church, and all L.I.C participants, plus a few from M.C.A.N saw God as a comforter (54.0%).

All participants from the L.I.C and M.C.A.N who selected the option 'Other' which constituted (100%) gave prominent views portraying God in many ways as set out below.

L.I.C participants view god Wanyonyi both apophatically and anthropomorphically. *Wanyonyi* their god is both immanent as Jehovah *Wanyonyi* with them in human appearance, but Jehovah Wanyonyi is also transcendent. His transcendence was explained using his 'disappearance from public'[51] view to mean Jehovah *Wanyonyi* remains their god, but the understanding is that he took on another form and has been withdrawn from people since 2015. Participants also said Jehovah has power to heal, accepts offerings, forgives, protects, answers prayers, is good, and blesses them when they follow commandments. Jehovah *Wanyonyi* not only cares and wishes people well, but he is believed to be almighty and creator of all.

M.C.A.N participants on the other hand view the almighty God as being transcendent but has sent the prophet to do the healing work. They encounter God in the rituals and life within the community and church. They see God who removes pain, gives them peace, uses *Nabii Yohana* to heal people, God who removes curses, evil dreams and protects people from harm, danger, or evil forces.

2.9 Forms of care and counseling support

Based on the data, individual, group, couple and marriage and a mixture of individual and family forms of counseling in L.I.C and M.C.A.N were pointed out. This also hinted at communal,

[50] M.C.A.N congregation believe in the almighty God that all Christians believe in but give more loyalty to Nabii Yohana whom they believe was appointed by God to help them. L.I.C refer to Jehovah *Wanyonyi* as their highest deity, different from YHWH (Yahweh), Jehovah of the Christians and Hebrew people.

[51] The world interpreted the absence as death but the adherents of L.I.C understands and believed that their god cannot die. He is still alive, as he only took on another assignment, but is in communication and relationship with adherents. The high priest says, "Our God is not like any ordinary human being who dies. He has been with us here and he will come back. The fact that you non-believers are not seeing him does not mean that he is dead," (Ominde, Nation, 16 October 2020). Since the death of Jehovah *Wanyonyi*, his adherents have strongly countered any rumours about his death or disappearance in public. Even though they expressed that they are constantly mocked and ridiculed for believing in a dead god, Jehovah *Wanyonyi, this is not the case.* To them Jehovah still lives. The death of the founder and leader of L.I.C threw the congregation into public ridicule, marginalization, and succession struggle with some wanting his younger son to take the mantle. The high priest Eliab is the interim leader of the L.I.C, and doubles up as head of the congregation and official leader administering rituals, prayers, and blessings. Spiritually, the congregation, stand out to defend their faith, express optimism and eschatological hope that they will be reunited with their god and Jesus.

individual, or integrated modes of supporting care-seekers present in L.I.C and M.C.A.N. From the data it became clear that M.C.A.N preferred the individual model, while L.I.C preferred the communal, but also allowed the use of individual and communal forms of counseling. Through the form of counseling, caregivers give advice to care-seekers on issues with which they are challenged and share what to do in the immediate and during long-term care. Figure 2.13 depicts the forms of counseling that are found in L.I.C and M.C.A.N.

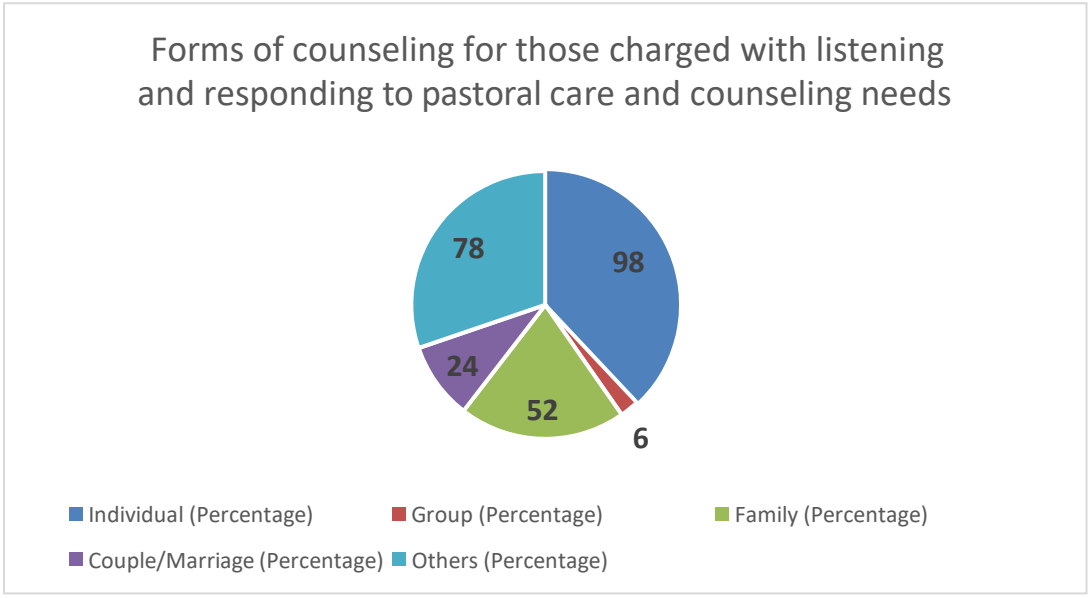

Figure 2-13: Forms of counseling in L.I.C and M.C.A.N

The bulk of participants said the L.I.C and M.C.A.N churches use individual counseling (98.0%) to listen and respond to the needs and challenges faced so they can cope. For instance, one participant said that 'only one person at a time' goes in to be served by the caregiver. Another participant said, 'only one person' is allowed in the sacred space to be seen by the caregiver. A significant number said family (52.0%) counseling is done in the church. These were mainly from L.I.C that follows a communal approach to ministry. A few participants (2%) from the 52% who said family counseling is done, were from M.C.A.N. One participant from L.I.C said, 'family must be involved', another participant said, 'one person and his or her family are involved'. Another participant said, 'an individual and family are talked to'. A few participants said group counseling is used. One participant said it begins with one person but 'ends up in group', especially husband and wife. One participant said, 'both husband and wife can go in together to see the caregiver'. Upon meeting, the caregiver follows steps to listen and talk to the care-seekers as explained in the section below.

2.9.1 Steps in procedure of pastoral counseling

L.I.C and M.C.A.N follow procedures in pastoral counseling as depicted in the table below. These steps are structured in L.I.C and more fluid in M.C.A.N. After the follow-up and the presentation of a gift of appreciation to *Nabii* in M.C.A.N, the door is left open for other visits should the care-seeker need advice from *Nabii* or healers. In L.I.C, *Mama Kanisa* and the high Priest continue to receive requests for other care needs, using L.I.C structure of advising.

While in M.C.A.N secrecy is a very key thing whereby care-seekers are forbidden to mention anything to people as they go for care or come back, it is open in L.I.C. Participants can talk about their care needs. It is only privileged information about the church that care-seekers are not allowed to share. The difference between the informal pastoral care handling of information in L.I.C and M.C.A.N, and formal pastoral care and counseling, is that in formal pastoral care and counseling information is shared during referral counseling for the safety of care-seeker and connections, for legal or court cases, or improved and effective care, and support, amid confidentiality undertaking.

Seclusion of care-seekers at the church is uniquely M.C.A.N. Care-seekers are withdrawn from home and public and taken care of, using spiritual resources at the church compound and only released when they feel better. L.I.C cares for people in their homes. Purity laws are mainly observed in L.I.C. Care-seekers who need advice make sure they remain uncontaminated – by not touching dead bodies – both human and animal. When in menses women must stay away until their menses is over. After giving birth, women stay away until the time is right according to the Levitical codes. Exorcism is mainly done in M.C.A.N where a healer binds demons; negative forces or evil spirits. Commonalities are visitations, assessment, appreciation of service given, gifts and offering and open policy for care at any time.

Table 2-4: Procedure of pastoral counseling in L.I.C and M.C.A.N

M.C.A.N	L.I.C
Step 1. Welcome and intention	Step 1. Welcome and building relationship
Care-seeker explains reason for visit – help;	care-seeker visit assured all will be well.
Step 2. Presentation of challenge;	Step 2. Invitation to tell the story.
Prophetic trance /utterances of caregiver;	care-seeker openly shares issues.
Step 3. Foreseeing	Step 3. Diagnosis
Explain issues / confirmation by care-seeker	clarifying issues and steps (code, laws)
Step 4. Prescription	Step. 4. Assessment and prescription
Need / care resources list /time place	Need / resources / when / roles
Oil	Oil
Gift / offering / sacrificial animal / bird	Gift offering / sacrificial animal
Anointing / herbal care	Anointing / prayer
Holy touch by *Nabii*	Touch by care-seeker

M.C.A.N	L.I.C
Shrine / sanctuary / ritual	Altar ritual
Healing action	Mention needs to Jehovah / offering / sacrifice / prayer
Exorcism / bind spirits	Advise / laws
Instructions / advise	Days of stay home / purity code
Days of seclusion / herbal bath	Interpret situation and solution through bible
Uncurse and holy leg touch by *Nabii*	Touch head of animal
Step 5. Administration of care	Step 5. Administration of care
Addressing need	Address issues
Determining gifts and sacrifices	Tell care-seekers the type of gifts /sacrifices and offerings
Giving gifts and sacrifices	bring gifts / sacrifice/ money /
Ritual action	Ritual care plan
Cooperate with healer	Acceptance of care
Trust healer	Believe in Jehovah
Revisit / confirm healing	Confirm healing
Step 6. Follow up	Step 6 Follow-up
Assess progress	Prayers / blessing
Appreciation / healing gift to *Nabii*	Thanks, offering to Jehovah
Open to care at any time when the need arises or as guided by *Nabii*	Open to care at any time or need, and follows the structure led by *Mama Kanisa* and high priest

2.10 Care-seeker roles

The following figure shows 24 major aspects that form part of what members in both L.I.C and M.C.A.N do when they need pastoral care as they work with their caregivers or healers.

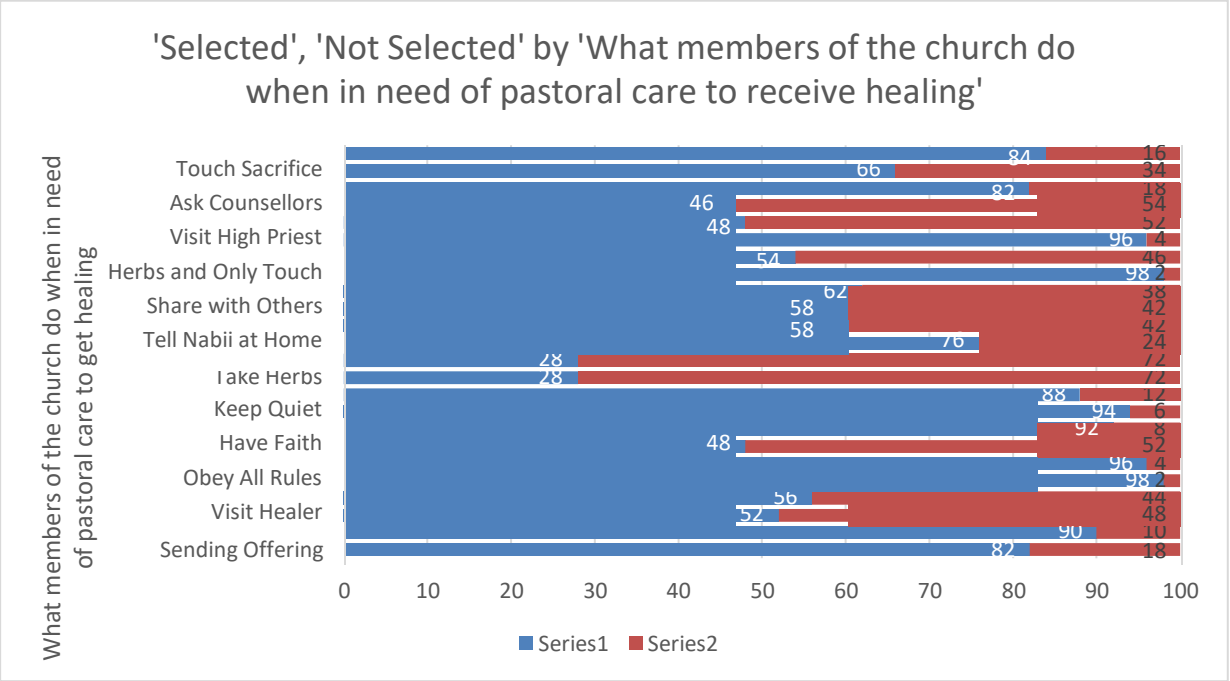

Figure 2-14: What members of the church do when they need pastoral care

From the data it becomes evident that visits, touching, obeying rules, herbals, accepting care, keeping quiet, and faith in Jehovah were rated high at 98 or 96% because rules, secrecy, faith in leaders and accepting care play a key role in the approach followed in the churches. However, some participants said, 'taking gifts' (28%) and 'herbal care' (28%) were rated low because occasionally members cannot afford it due to poverty.

The majority of participants selected main roles of care-seekers as: use of herbsand accepting the holy touch (98.0%). Touch in this case is the touch of the leg by *Nabii* in M.C.A.N (49%), and the touch of the animal to be slaughtered by L.I.C care-seeker (49%). Participants selected obey all rules (98.0%) because the L.I.C have the laws of Moses and the 10 commandments to be obeyed (49%). M.C.A.N participants in this case must follow 12 commandments, the constitution and strict instructions given by *Nabii* (49%). Participants from L.I.C and M.C.A.N chose faith in Jehovah at (96.0%). In this respect, L.I.C referred to the immanent human-divine deity (48%), while M.C.A.N referred to the transcendent God (48%). 'Visit high priest' was what participants said they do when needing care in both M.C.A.N and L.I.C (96.0%). Similarly, participants from LIC and MCAN selected 'keep quiet' (94.0%). They said that they are not allowed to talk about or share information concerning their care with anyone. L.I.C participants on the one hand said they always refrain from sharing internal information with outsiders. M.C.A.N on the other hand refrain from talking to people on the way to the church for healing and when coming back home.

Participants from both L.I.C and M.C.A.N also said they ‘accept care’ (92.0%) that is provided by the caregivers as they are denied the option of refusing.

The participants also added ‘use herbs and touch’ at a high percentage (98.0%). In L.I.C, at personal level, herbs and touch are given in community, while in M.C.A.N herbs and touch are given in church for all people or individuals in community who accept the holy leg healing touch of *Nabii*. For those who selected ‘ask diviners’ (82.0%), participants said they independently go out to seek the assistance of healers outside the L.I.C and M.C.A.N churches when challenges persist.

62.0% of the participants also selected ‘prayers and take medicine’. This means that participants believe as they trust God and pray to Him and Jehovah for healing, but also take herbal medicine in community (accept healing prayers but also take herbal medicine).

During home visits, 50% out of 76% of care-seekers in M.C.A.N tell Nabii about their needs at home. The remaining 26.0% from L.I.C care-seekers also privately visit other healers, including Nabii. They always take reports of any needs to religious leaders, especially *Mama Kanisa* at the church.

A significant number of participants indicated the following as roles of care-seekers in care; share with others to help (58.0%), inform the need to other leaders (in L.I.C), lie down on holy mat for healing (58.0%) (M.C.A.N), touch sacrifice (66.0%) (L.I.C, a few from M.C.A.N) ask counsellors from outside such as from hospitals or schools (46.0%) (in L.I.C), follow teachings (48.0%) (in L.I.C), visit healer (52.0%) (in M.C.A.N), visit other pastors (56.0%) (in M.C.A.N and LIC). A few participants said they take gifts (28.0%). The low number indicates difficulty in fulfilling this important requirement since most people (L.I.C and M.C.A.N) have low or no income whatsoever.

Participants taking herbs (28.0%) is indicative of low visits because one must have money to give to herbalists to effect healing and when they have no money, they do not visit; hence taking of herbs is minimal. Qualitative findings show that care-seekers visit (L.I.C and M.C.A.N), maintain trust and faith in healing (both L.I.C and M.C.A.N), and visit leaders in church and neighbouring churches for care (L.I.C and M.C.A.N). They also accept prayer and holy touch for healing and at the same time use medicine but seek help of counsellors in hospitals, schools, and other churches. (L.I.C and M.C.A.N).

2.11 Knowledge and skills for care

Participants were asked to give information about the understanding and abilities of caregivers about pastoral care and counseling that helps them as they care for and give support to people in both L.I.C and M.C.A.N churches. From the data obtained, caregivers' knowledge and skills were passed on from founders to other members and to later groups who joined the churches.

There is no formal training in either of the churches, since caregivers learn through observing senior members of their churches perform the caregiving tasks, and through informal training done by experienced men and women caregivers from within community settings.

The L.I.C and M.C.A.N acquisition of skills and knowledge differs significantly from the formal pastoral care and counseling where knowledge and skills are acquired from specialized formal training in theological and counseling institutions for a specified period. Communication skills and core conditions of care are used in formal care while oral community-focused or caregiver-specific ways are used in informal care

Knowledge and skills are important because they determine the way in which care is administered to care-seekers. See knowledge and skills from data projected in figure 2-15 below.

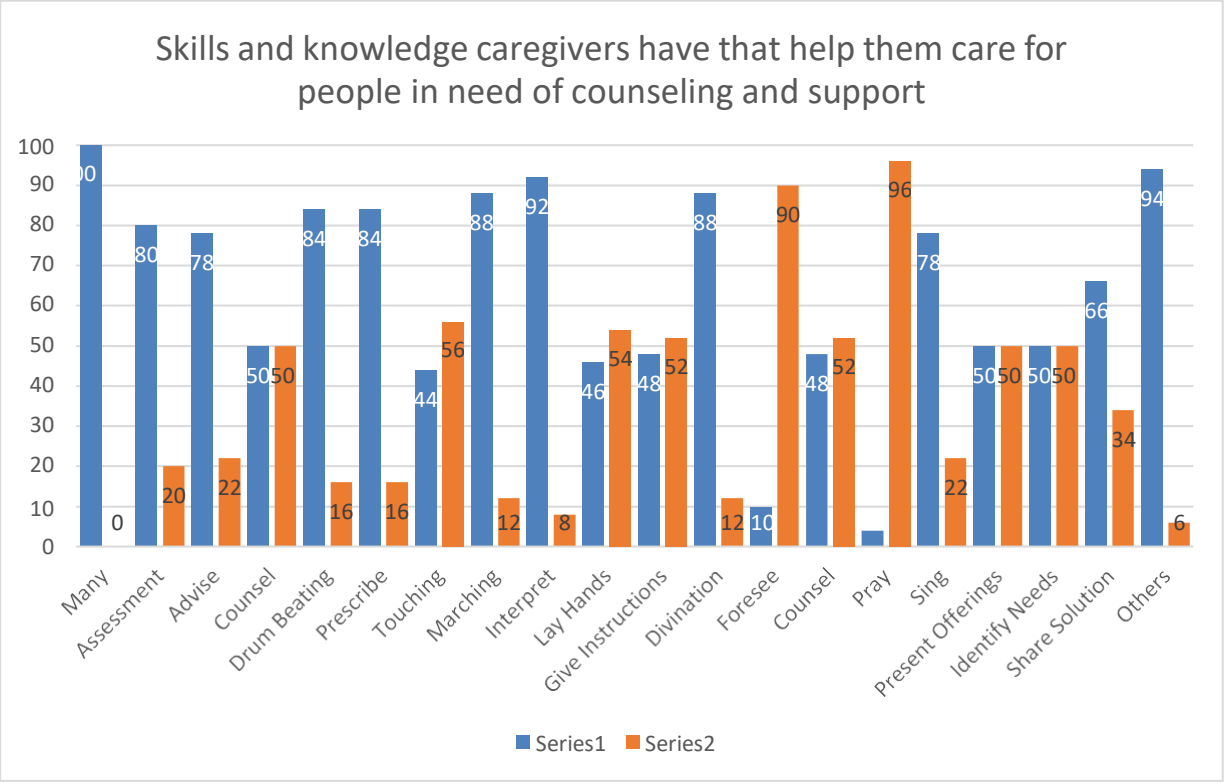

Figure 2-15: Knowledge and skills for care

The majority of participants were aware of skills that fall within the categories of spiritual and experiential roles in care giving. It was evident when participants from the two churches indicating 'many years' at (100%). Out of this percentage, 50% represented skilful working. Jehovah and healers had over 60 years of caregiving and support to the needy in L.I.C. The senior leadership allow the young to observe and learn from them. Another 50% represented M.C.A.N where *Nabii* of M.C.A.N had many years of experience as he started work from the onset and he does that every day as he perfects the skill. All those members who join and are appointed as disciples or healers observe how Nabii works, and the older caregivers do pass on the caregiving skills to younger caregivers

Interpretation of issues through reading the bible was at (92.0%). It is one of the skills among the skills in caregiving that *Mama Kanisa* of L.I.C acquired from Jehovah Wanyonyi and has done it for many
years now. Hence observation and practice over a period of reading and interpreting scripture in pastoral care and pastoral counseling from senior leaders in the churches is key. This observation and many years of practice applies to all caregiving. Participants being aware of assessment of the needs by caregivers rated at (80.0%) (in L.I.C and M.C.A.N), prescribing care at (84.0%) (L.I.C and M.C.A.N) that help specify the needs, and treatment options. The participants were also aware of drum beating in which L.I.C church specializes, but also shared by members from M.C.A.N rated at (84.0%) although this experience is outside M.C.A.N. L.I.C has marching (88.0%) as a spiritual and healing exercise accompanied by songs at (84.0%) that accompany healing all the while.

Participants from both M.C.A.N and L.I.C; selected praise at (78%), and trust in Jehovah *Wanyonyi (who is believed to still live on)* for (L.I.C), and trust in the almighty God for M.C.A.N from whom they ask for mercy and healing for those who need healing. Participants selected divination at (88.0%) saying that care is attained through divination where caregivers give herbal medicine, majorly in M.C.A.N, but also in L.I.C. This includes administering herbal medicine and foretelling what care-seekers' situation is or will be like in the near future.

Participants selected 'give advice' at (78.0%) where full advice is given in L.I.C, but directives or commands are given by Nabii to care-seekers in M.C.A.N. Participants additionally said that care is given by sharing solutions with care-seekers which was rated at (66.0%). Here all L.I.C participants selected 'share solutions' with few from M.C.A.N saying that it is partly done. Care also includes identifying the needs (50.0%) in the L.I.C church, and doing counseling rated at

(50.0%) in L.I.C, which takes the form of giving advice on what to do after the visit and while at home. Giving advice is one way in which the caregiver has authority and power over the care-seeker, and the care-seeker obliges without questioning. Caregivers give strict guidelines to be followed by care-seekers such as keeping purity laws, obeying commandments, following all the laws, including not talking about personal and church issues in public.

A few participants were aware of other significant skills of caregivers such as touch (44.0%), and this refers mainly to holy leg touch in M.C.A.N. Caregivers use the holy leg touch for connecting the healing to the part that aches or pains. Similarly, L.I.C care-seekers touch the head of the sacrificial animal so that their troubles and challenges are taken away by the lamb or goat to be sacrificed. Giving instructions rated at (48.0%) is done by healers was selected mainly by M.C.A.N as the care-seekers must obey the constitution, and the 12 commandments and instructions from *Nabii.* At the same time individual conduct of the care-seeker such as not greeting people on the way to and from healing activity, not looking back after leaving the church healing space and using the herbal medicine as required. In the qualitative study, leaders who were mostly older than the members of the church, gave more information than the members on the knowledge concerning care given in their respective churches.

Other helping skills pointed out include the following, as depicted in table 2-5.

Table 2-5: Additional skills for care in L.I.C and M.C.A.N

Category	Skill	Church
Spiritual power	Ability to search and locate evil charms, remove curses, remove bones and broken bottles from the body; Overshadow evil forces, locate harm, exorcise demons and bad spirits; Block people with evil eyes from harming others; Revoke evil forces, cast spells, confuse bad people.	M.C.A.N
	See other needs of people that are not mentioned.	L.I.C and M.C.A.N
Connections	Ability to see and explain serious problems to people; Allowing people to share with caregiver.	M.C.A.N

Category	Skill	Church
	Unwavering ability to stand with the challenged and assuring the challenged that they will be okay	L.I.C
Application	Interpret the bible to the care-seekers	L.I.C and M.C.A. N
	Ability to intercede for care seekers to God, Jehovah, ability to call people through songs.	L.I.C
	Link care-seekers up with ancestors	M.C.A.N

2.12 Spiritual Care resources

Participants in the quantitative study identified 'three main[52]' spiritual resources used in pastoral care and counseling in L.I.C and M.C.A.N as set out below. However, in the narrative qualitative section of those who selected 'others', participants added more than 50 spiritual resources. Bible, oils, songs appeared again in the main qualitative data; a confirmation of how significant the resources are in the care and healing ministries of the two churches. However, it was noted that more participants of L.I.C mentioned the bible as a spiritual resource unlike M.C.A.N since every challenge in L.I.C must be interpreted through reading scripture. Songs were dominant in L.I.C. A common identification of the deities; thus 'God' and 'Jehovah *Wanyonyi'* by M.C.A.N and L.I.C respectively shows how important the place of the deity is in the care. Participants see direct involvement of the deity; hence depend on and trust their deity for care, good health, and blessing. This is equally seen in the 'Biblical pastoral care models'[53] that show the relationship with and dependence on God as being important, unlike the western models of psychotherapy.

[52] Bibles, songs, and holy oil.

[53] Breed, G 2015; Breed, G, Letsosa, RS, and Pieterse, HJC. 2014.With Eyes on God. Presuppositions of the Reformed Perspectives on Doing practical Theology. NWU; Louw, DJ. 2016:523-527 & De Klerk & De Wet, 2014:11-12.

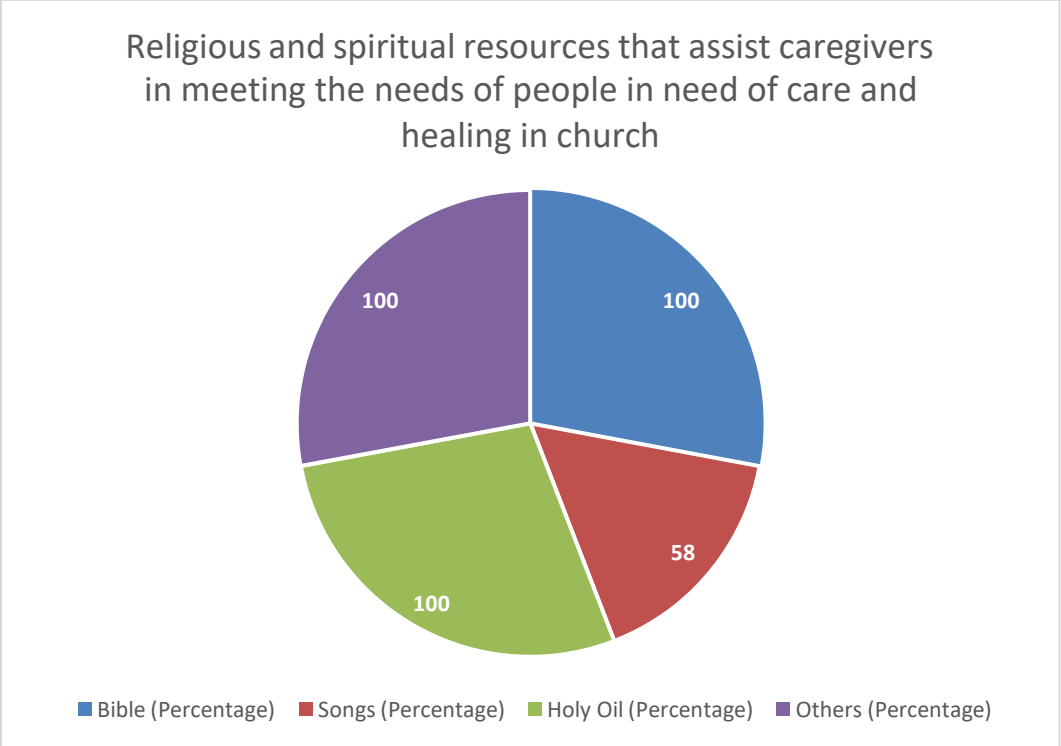

Figure 2-16: Religious and spiritual resources

All participants indicated that the Bible (100%) and holy oil (100%) are key spiritual resources that assist caregivers in meeting the needs of people in need of care and healing. The L.I.C church uses *Agano la Kale* (the Old Testament Bible in Kiswahili). *Mama Kanisa* randomly picks a scriptural text to read and interprets the issues during pastoral care and pastoral counseling sessions. The M.C.A.N church has a different scripture, and not the version that Christian churches use. Nabii uses *Agano Jipya and Agano la Mwisho* (the Last and final testament), a bible Nabii has written. This bible has 30 extra books with different names from those of the Old and New Testament. Holy oil is used by M.C.A.N and L.I.C churches in the care. Holy oil is applied as a sign of blessing, healing and wellness for the care-seeker. Songs (58.0%) are used to comfort, praise the deity, encourage, or warn the care-seekers mostly in the L.I.C. However, some M.C.A.N participants have experienced use of songs in care outside their church. There are other spiritual resources that are used in care and are symbolic, for instance stones, flags, attires, sword, amongst others.

In the qualitative data all participants added the following to the list of spiritual resources, as indicated in table 2-6 below.

Table 2-6: Other Spiritual resources indicated by L.I.C and M.C.A.N

Nature	Spiritual resources	Church
Symbolic resources	Altar, holy ground, drums, flute, holy ground, candle, crown and holy seat of Jehovah, chuma (metal) ring, sword, candle, incense,	L.I.C
	Bible, flags, Attires	L.I.C and M.C.A.N
	Sanctuary, 12 flags, 12 holy stones, holy mat, new bible, constitution, shrine	M.C.A.N
Religious leaders	*Mama Kanisa* (Church woman-leader), high priest, judges, shepherds, angels branch leaders	L.I.C
	Teachers, preachers, disciples, praying women warriors, healers, *Nabii Yohana*	M.C.A.N
Deity	Jehovah *Wanyonyi*	L.I.C
	God	M.C.A.N
Doctrines	Bible, 10 commandments, holy sabbath, law of Moses, trust and faith in healing by Jehovah, sacrificial rituals, sacrifices and gifts for healing, *batambi ba Jehovah* (the poor of Jehovah)	L.I.C
	Healing power from God to *Nabii Yohana*,12 commandments, Constitution, Prophecy, herbal care	M.C.A.N
Medicine and gifts	Herbal medicine, bracelets, holy water, chicken	L.I.C
	Holy oil, sacrifice animals,	L.I.C and M.C.A.N
	Incense, whisky, money,	M.C.A.N
Teachings and beliefs	Prayer, sadaka (offering), faith in Jehovah,	L.I.C
	Trust power of *Nabii*, church space,	M.C.A.N
Spiritual exercise	Song, dance, marching, clapping, special	L.I.C
	Holy leg touch, prostrate	M.C.A.N

2.13 Beliefs and Doctrines

Beliefs and doctrinal tenet variables are extremely important because they assist the researcher in gaining an in-depth understanding of the basis of teachings about faith formation and beliefs exhibited among a specific church group that is acted out in their relationships, religious activities and behaviour. The beliefs and doctrinal tenets that influence strategies of care and counseling in

L.I.C and M.C.A.N are divided into five major categories; thus faith, sacred space, deity and religious leaders, commandments and laws and threats to life.

Variables such as following rules, the law of Moses, 10 or 12 commandments, respecting the sabbath and remaining pure give insight into the stipulated guidelines on the 'dos and the don'ts' of either church, or on how they impact care for care-seekers. Some rules can be too legalistic; standing in the way of care (conditional). See summary below concerning beliefs and teaching that inform care in L.I.C and M.C.A.N

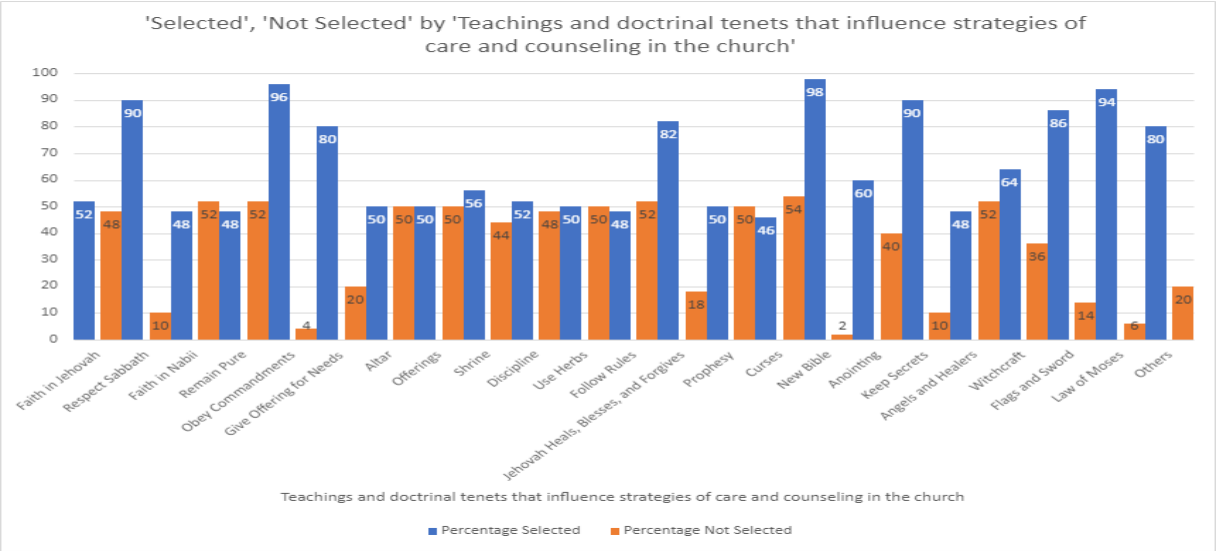

Figure 2-17: Teachings and doctrinal tenets

The majority of participants said churches indicated that teachings about the bible (98.0%) are core in the churches' beliefs and doctrine. L.I.C participants believe the bible is the word of God that guides them in their spiritual journey and lives, and they believe it is what God speaks to them through the different writers. They also believe that what God told the Israelites from long ago is also their word as they are but Lost Israelites in Kenya.

Hence, they take seriously what the word says, and do as the word instructs them through scripture in particular. The L.I.C uses books of the Old Testament and are guided in practice by the Levitical codes and general law of Moses. M.C.A.N on the other hand uses the Old Testament and the New Testament in the new bible that was written by *Nabii.* M.C.A.N believes that God spoke to *Nabii* to re-write the Christian Bible and revealed extra new books to him, which are good teachings for their spiritual life and Christian practice. Both the L.I.C and M.C.A.N members are keen on keeping the law of Moses (94.0%). Moral laws, purity codes and religious life is strictly based on

the teachings of Moses in L.I.C whereas M.C.A.N follows traditional teachings of *Nabii*, in as much as they purport to follow the Old Testament.

Both churches (L.I.C and M.C.A.N) observe a high level of secrecy, for they keep church secrets (90.0%) among members. Other teachings that directly affect care provision in the churches are about prophesies (M.C.A.N), about purity codes (L.I.C) and centrality, and requirements for offerings and sacrifices are derived from the Levitical codes and the five books of the Jewish scripture in the Old Testament (L.I.C). The Bible, law of Moses and keeping secrets regulate the behaviour of believers, namely, to abstain from anything that would make them unholy, to observe the day of the lord, to honour and respect the deity and church leaders, and to have faith in the power of healing from the deity and representative religious healers in L.I.C. The new bible (98.0%) with *Nabii Yohana's* message also teaches about faith. God is used by M.C.A.N which portrays *Nabii* as the last prophet sent by God with power to heal, and teaches how believers are to conduct themselves. Apart from the founders, leaders such as angels and healers (48.0%) are taught, since they are instrumental in implementing the daily care of people experiencing challenges.

Participants say they are also taught to revere and approach sacred spaces with humility; sacred spaces where we have the altar (50.0%) in (L.I.C). All participants of M.C.A.N and few of L.I.C who seek care outside their church selected as the shrine (56.0%). Ritual activities in M.C.A.N are done in the shrine, the 'houses and the sanctuary and around the holy stones.

L.I.C uses the Sword and holy flag (80.0%) for healing. The holy sword is for a symbol of power against evil. The 12 flags represent 12 tribes of Israel, and completeness or representation of everybody. Sacred space is important, and it is believed that God is present there and is to be honoured (L.I.C). They respect the sacred space and only touch or visit where participants are allowed. They are also taught the significance of sacred spaces in healing relationships. Participants also said they believe and trust that the healing power of Jehovah *Wanyonyi* is present in the sacred space. L.I.C ensures high Discipline (52.0%), and behaviour is maintained through rules (48.0%) that leadership of the church use to govern the spiritual lives and behaviour of individual congregations every day, for instance ensuring that people remain pure (48.0%). M.C.A.N on the other hand use herbal medicine (50.0%) give offerings (50.0%), listen to prophesy (50.0%) teach about curses (46.0%) and witchcraft (64.0%) and how they will be removed, and also how people could become well through anointment (60.0%).

The qualitative study showed that the majority of participants said teachings and beliefs about the Christian Bible and the new bible, religious leaders, sacred space, sacrifices, offerings and religious leaders (M.C.A.N and L.I.C), the law of Moses and commandments, purity, faith in Jehovah Wanyonyi and his healing powers in L.I.C are particularly important in giving care. Some of these resources were mentioned earlier in the quantitative research, a confirmation and emphasis on their importance of care.

The M.C.A.N church teaches about the almighty God, Nabii, women prayer warriors, healers and disciples and their contribution to healing. Similarly, they teach about herbal care, prophesy, and anointing, and they believe that leaders are useful in pastoral care and pastoral counseling and healing of care- seekers; hence accord them high respect.

2.14 Challenges in seeking care.

Research findings indicated that both L.I.C and M.C.A.N shared most of the challenges they experience while seeking care. Some challenges are common while others are unique to individual churches as indicated in figure 2.18 below. Variables such as stigma and ridicule, lack of respect, being shunned, treated as different and lack of support may show low percentages, but assist the researcher in gaining awareness on some of the aspects that show strain in the relationships between churches and communities. These also are pointers or explain how poverty and lack of education and unemployment may lie behind variables such as lack of food, no jobs, no money, lack of transport, inability to buy gifts, and delayed care. Find below the summary of challenges in figure 2.16, table 2.7 and in a follow-up explanation.

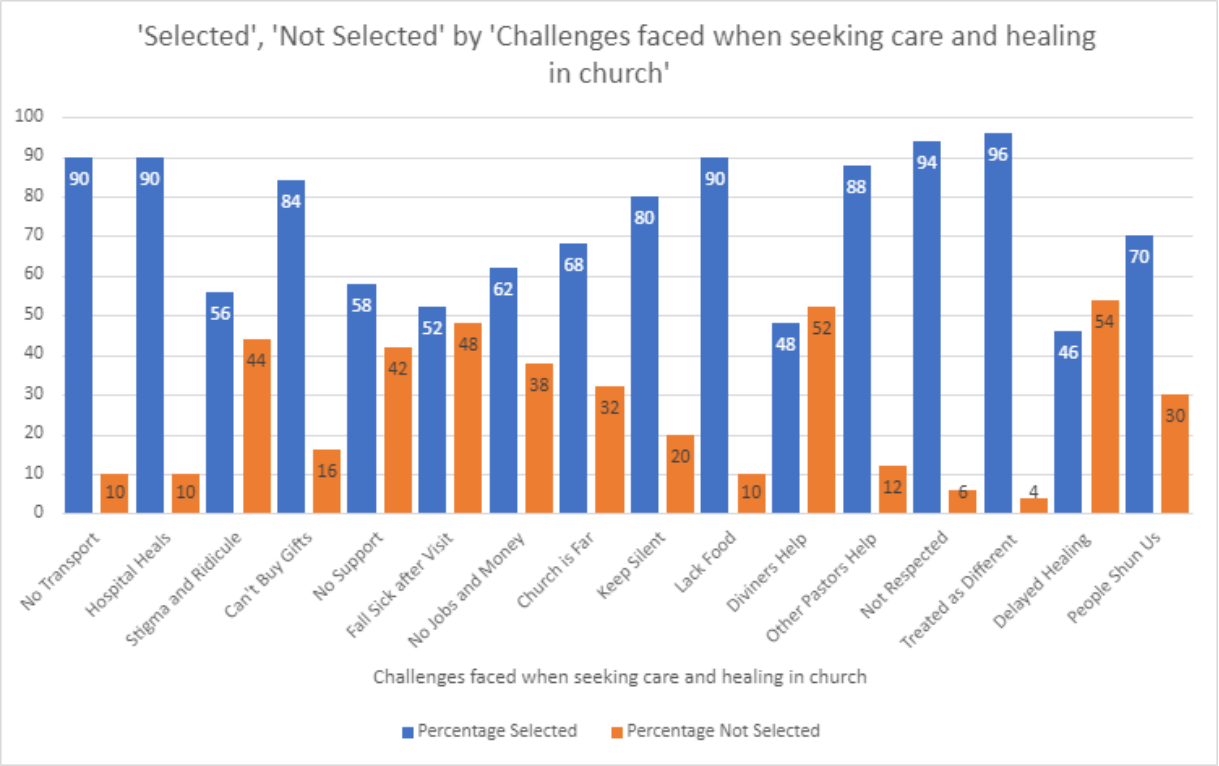

Figure 2-18: Challenges faced when seeking care and healing in the church

The majority of participants indicated that people struggle with material, physical, financial, psychological and social challenges. The lack of food (90.0%) such as daily food for the families and their children's school fees was a major concern in both M.C.A.N and L.I.C. This leads to malnutrition, which makes them prone to ill health. Similarly, stigma and ridicule (56.0%), being treated as different (96.0%), being shunned (70.0%) by people from the neighbourhood and other churches, not being respected (94.0%) was felt by L.I.C participants, even though some M.C.A.N participants expressed the same experiences. The afore-mentioned challenges lead to increased psychological, emotional, and social distress to care-seekers such as fear, hatred, anger, bitterness, stress, depression, and low self-esteem among people. The strained relationship minimizes any support (58.0%) in L.I.C and M.C.A.N as many lack support. Due to poverty and low level of education, unemployment is high, and this has led to lack of jobs and money (62.0%) in both L.I.C and M.C.A.N. This further translates into inability to buy gifts (84.0%) (in L.I.C and M.C.A.N) and inability to afford transport (90.0%) in L.I.C as well as in M.C.A.N. Distance is an issue for participants. They said the church is far (68.0%) for care; hence delayed healing (46.0%) in M.C.A.N. Other challenges that were pointed out several times by participants include the following as indicated in table 2-7:

Table 2-7: Other Challenges faced when seeking care and healing in L.I.C and M.C.A.N

Type	Challenges	Church
Negative forces	Warfare, demonic attacks, curses, witchcraft, animals not productive, misfortunes, generational curses, evil eyes	M.C.A.N
	Bad dreams, bad spirits, not passing exams, sleeplessness, jealousy, hatred, grudges, mental challenges,	L.I.C
Relationships	Lack of love, not being married, childlessness, fear, anger, frustration, hatred, bitterness, not forgiving, hurt, suspicion, bad relationships, grudges	M.C.A. N
	Challenges of widowhood and need for re-marriage, no one else to tell my issues, people do not feel free to come to us, loneliness, anxiety, rejection, stress, depression, hopelessness, not forgiving, lack of trust, bitterness,	L.I.C
Threat to life	Sickness that does not heal, bereavement on and off, children are challenged, sick all the time, family problems, unending headache and stomach-ache	L.I.C
	Many problems, child deaths, unknown frequent deaths all the time, frequent illness – strong headache, and stomach-ache, tragedies, loss	M.C.A.N
Poverty	Not having money for food for a long time, Lack of transport lack of daily needs	M.C.A.N
	lack food, lack money to purchase gifts, lack of fees, No church structure	L.I.C

Participants were not aware of how strict rules not being obeyed stand in the way of pastoral care and pastoral counseling. In both churches, total obedience is observed, and this places a huge amount of pressure. The relationship is not balanced and due to authority, caregivers can have advantage over the members. Rules that demand that the members keep secrets through the culture of silence, can make care-seekers to suffer in silence, even when they can be helped if they had

asked other caregivers to support them. Laws and rules can also create fear and intimidation of care-seekers and make them unable to seek help.

2.15 What will improve care?

Participants identified four variables they saw would make the L.I.C and M.C.A.N churches improve care and counseling support needed for healing. The areas are formal training in pastoral care and counseling, proper pastoral care and counseling, inter-church exchange and exposure visits, awareness of appropriate use of spiritual resources in pastoral care and counseling, as portrayed below in figure 2.19 below. Receiving feedback from participants to identify what they felt needed to be done, reveals the areas of need in the caregiving strategy in both churches, and shows how giving advice, need for exposing leaders to caregiving in other churches' formal training, and increasing awareness on the use of spiritual resources, would add value and allow integration in caregiving.

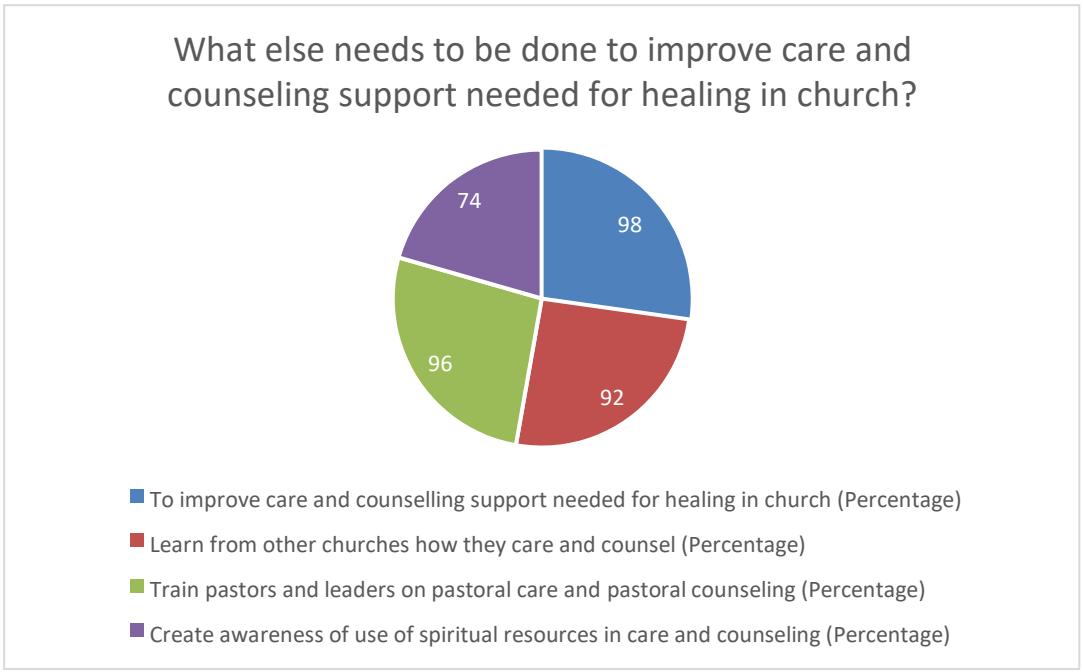

Figure 2-19: What is needed to improve care?

During the empirical research, participants suggested four areas that would improve care and counseling support as shown in figure 2-20 below. A significant number of participants indicated that there is a need to have mentorship, social and material support, added training and skills in pastoral care and pastoral counseling, clarification of use of spiritual resources that will impact pastoral care and counseling positively as shown in the summary in figure 2-19, and table 2-8

below. Training, counseling, and exposure were more prominent both in L.I.C and in M.C.A.N while creating more awareness was pointed out stronger by L.I.C.

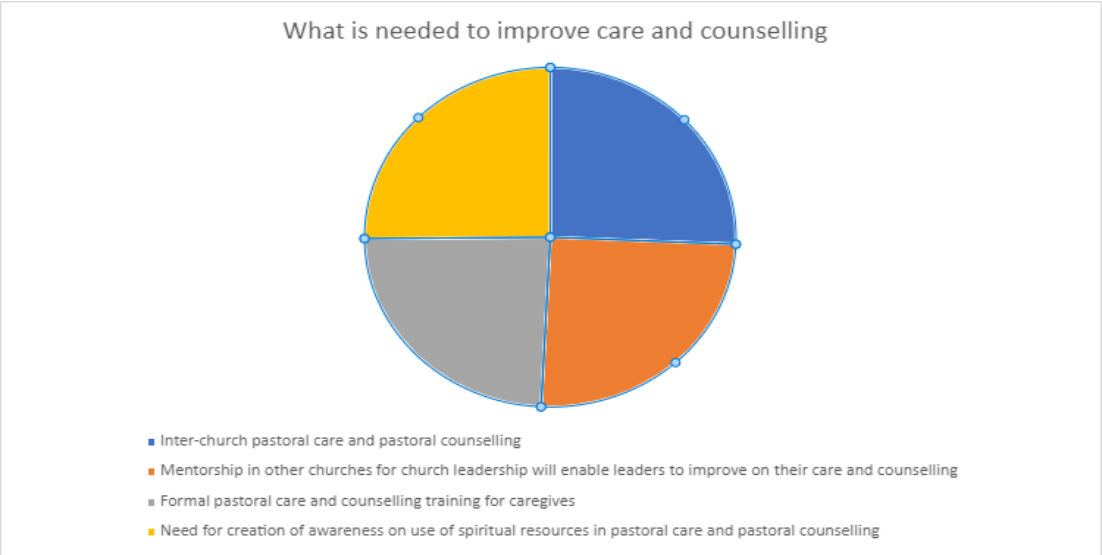

Figure 2-20: What is needed to improve care and counseling?

From the quantitative study, the majority of the participants (98.0%) suggested that inter-church pastoral care and pastoral counseling is one of the areas that needs to be improved (50.0% from L.I.C and 48.0% from M.C.A.N). They added (96.0%) that mentorship in other churches for church leadership will enable leaders to improve on their care and counseling (50.0% from L.I.C and 46.0% from M.C.A.N). Furthermore, participants (92.0%) also suggested that formal pastoral care and counseling training for caregivers in L.I.C (50.0%) and M.C.A.N (42.0%). Similarly, participants hinted that there is a need for creation of awareness (96.0%) on use of spiritual resources in pastoral care and pastoral counseling in L.I.C (50.0%) and M.C.AN (46.0%).

During the qualitative research, participants added other areas that, if considered, will improve the care and counseling of care-seekers, as shown in the following table. Furthermore, a significant number of participants indicated that there is a need for mentorship, social and material support, added training and skills in pastoral care and pastoral counseling, clarification of use of spiritual resource that will impact pastoral care and counseling positively as shown in the table below.

Table 2-8: What else is needed to improve pastoral care and counseling in L.I.C and M.C.A.N

Category	What is needed to improve care	
Finances	Financial support for transport for pastors who walk long distances, and money for fees for children of members of congregations, money for business for church groups	L.I.C and M.C.A.N
Material Support	Food, support with all other material needs	L.I.C and M,C,A,N
Space	Construction of a church to be like other churches	L.I.C
Spiritual	Strong prayers, support of other people,	L.I.C and M.C.A.N
Exposure	Visit other churches – benchmark, other churches visit L.I.C and M.C.A.N	L.I.C and M.C.A.N
Care	To be listened to by pastors, make it possible to talk to caregivers, exchange programs,	L.I.C and M.C.A.N
Relationships	Be respected and support pastors so they can support care-seekers, accept leaders,	L.I.C and M.C.A.N
Training	Workshop, seminar to train pastors to be like pastors in other churches	L.I.C

2.16 Alternative preferred care

Participants in the study said when they had alternative care options, they seek either privately or with the knowledge and permission of their churches as depicted in the figure below. Both qualitative and quantitative data indicated that the healing activities in their churches such as sacrifices, gifts, visitations, prayer, holy touch, interpretation of the bible and anointing with oil were very important and available in churches for care. However, participants also showed profound reliance on caregiving activities outside their own churches.

An open policy exists in the churches where care-seekers are not restricted at all from seeking care outside their churches. In certain cases, participants would be recommended by their church leaders to seek hospital care (L.I.C). Responses on alternative care options available gives insights on alternative pastoral care and counseling options available to care-seekers. The responses further show that community traditional care is provided by community caregivers alongside public secular care through schools and hospitals used to address the unmet needs in churches. The summary is given in the figure below

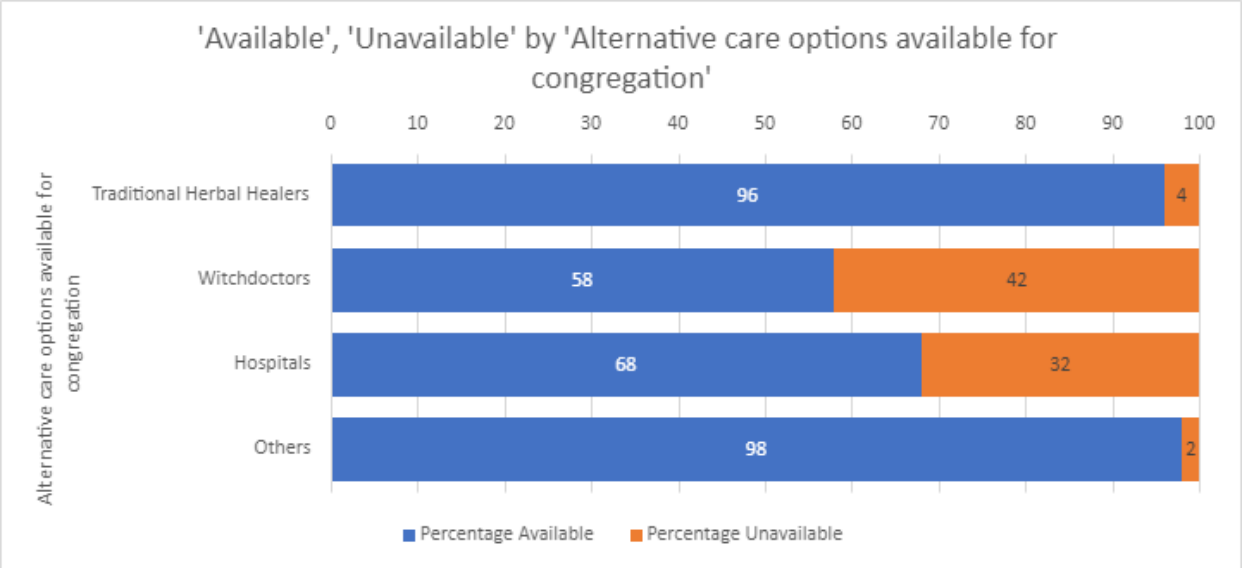

Figure 2-21: Alternative care options available

For the alternative care, traditional herbal healing was rated at (96.0%) while hospitals at (68.0%) were pointed out significantly by participants from the churches as being the preferred options of care for care-seekers in L.I.C and M.C.A.N. Traditional healers found in the community provide advice and treatment of illnesses and deal with daily support of care-seekers. Hospitals (68.0%) are visited privately by care-seekers for headache, persistent stomach-ache, skin conditions, and severe conditions that need hospitalization (L.I.C). Slightly more than half of the participants (58.0%) said witchdoctors would be an alternative option for care (all M.C.A.N and some from L.I.C). Care-seekers go to witchdoctors to counter evil forces, reverse effects of evil eyes and witchcraft. 98% participants selected other sources of alternative care. Those mentioned significantly include: other churches, visit seers, strong praying people (in M.C.A.N), pastors in other churches, praying and fasting, schools, faith-based organization, and good Samaritans (well-wishers) in L.I.C. The variables pointed out in the qualitative section together with the quantitative variables explain that there is no single care option for the source of care including faith-based institutions, government institutions, community traditional healers, other churches, hospitals, good Samaritans and churches. This also speaks to the type of needs participants have, for example educational, health, social, physical, spiritual, amongst other needs; satisfaction level with the church care options (not very high), and the preference to/for the traditional care options due to accessibility and affordability compared to church options that are far, of which the cost also is high for participants.

2.17 Rituals in care

Participants were asked to show how the religious rituals in their churches impacted their lives. From the qualitative data, participants profoundly pointed out that religious rituals provide them with social, psychological, spiritual, and emotional answers needed for healing. Participants, both in L.I.C and M.C.A.N, categorically said that rituals give them encouragement, blessings, and protection. One participant said 'rituals protect my family from evil eyes'. Another one said, 'rituals remove powers of witchcraft and reverses curses.' Another participant also said, 'I get healing and peace'. Similarly, other participants said that ritual care is important since people receive healing. Yet Another participant said, 'when very difficult diseases are not seen in hospital, they are treated through rituals', and 'children and the *boma* (homestead) are protected from evil through rituals in the church'. Another participant said 'rituals give me strength and make me not to worry or fear'.

2.18 Conclusion

The objective of this chapter was to describe faith healing beliefs and practices within the belief systems of L.I.C and M.C.A.N.

This chapter presented the background to the context of faith healing practices in the Kenyan context and L.I.C and M.C.A.N. The empirical research was done in L.I.C church in Chemororoch and M.C.A.N church in Bukembe. The study applied the MMR approach that comprised questionnaires and interviews with closed-ended and open-ended questions. A sample of 50 participants was taken from an active population of 550 active members. The participants were of an average age of 57 years. These participants were single, married or widowed, and were leaders and members of L.I.C and M.C.A.N. Data was analysed using the SPSS package, approved by NWU Statistics department, and thematic analysis.

The areas covered by questionnaires and interview questions included knowledge of pastoral and pastoral counseling services, activities, and responses to needs, caregiver and caregiver roles, God image and spiritual resources, knowledge and skills of caregivers and doctrines and beliefs influencing care, roles of rituals in care, suggestions with a view to improve care and finally, alternative preferred care. The study highlighted the challenges participants experience as they seek care, among which are poverty, ridicule, segregation, being shunned and treated as different, inability to afford care services and lack of support. To enable pastors and congregations in L.I.C and M.C.A.N to give pastoral care and counseling to care-seekers effectively, factors such as

relationships, knowledge and skills of pastoral care and counseling, religious and community resources, view of God, beliefs, practices, and doctrines need to be factored in. An integrated alternative model of Pastoral care and counseling based on Biblical principles can assist in achieving this.

CHAPTER 3: INTERDISCIPLINARY MODELS FOR PASTORAL CARE AND PASTORAL COUNSELING OF PEOPLE IN A.I.CS–INTERPRETIVE TASK

3.1 Introduction

In this chapter the researcher deals with the interpretive task as designed by Osmer (2008:4, 79-128). This encompassed responses to the question: 'Why is this going on?' Thus, the researcher undertook to look into the reasons leading to the situation experienced in the use of diverse models[54] of counseling and psychotherapy in helping professions. The interpretive task is portrayed below in figure 3.1.

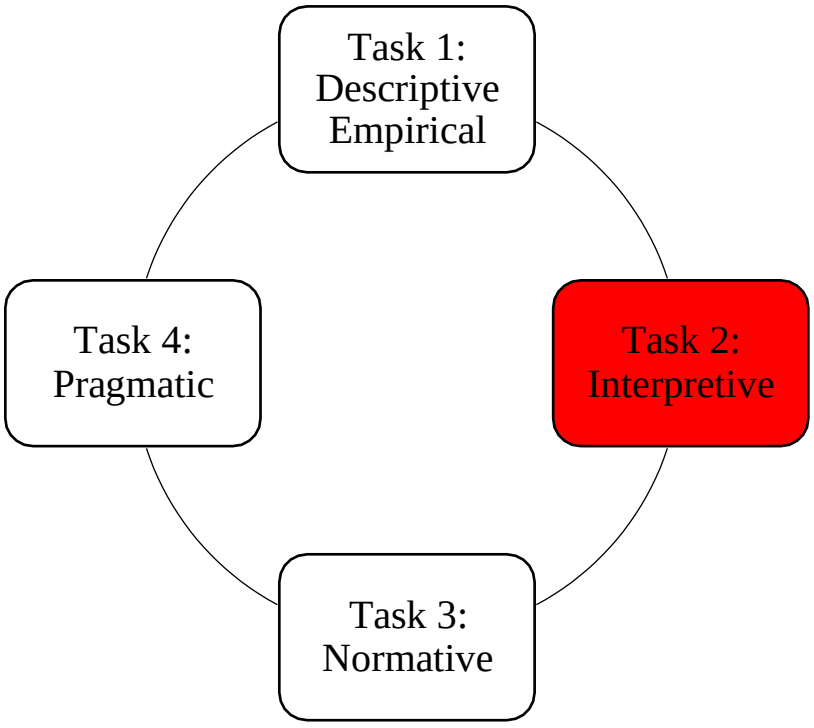

Figure 3-1: Interpretive task.

This assisted in understanding and explaining the patterns more clearly, and more importantly the dynamics occurring as counsellors use independently or collaboratively with other teams from fields different from their own in helping people cope with or address issues facing them in life. The researcher started off with a general introductory background before identifying and

[54] These will be psychosocial, African Counseling model and Biblical Pastoral counseling approaches that are used in therapy both in the developed world and Africa.

evaluating select 'models across disciplines'[55] used for counseling. Later, the researcher analysed models and gave a critique on the relevance of the dissimilar selected models in counseling people with faith healing tendencies within the belief systems of A.I.C. The nature, definition and scope of models will be clarified, and thereafter functions and goals of identified models in counseling were discussed. Similarly, common and divergent elements of the identified models pointed out while stating their relevance to effective healing of people in need of care. Lastly, critique is offered of identified interdisciplinary models of counseling. A detailed description is given of selected 'pastoral models'[56] to clarify the processes, principles, phases and stages involved in the pastoral models of counseling. Selected pastoral models guide frameworks that will assist the researcher later in developing a model for counseling challenged people with faith healing tendencies within belief systems of L.I.C and M.C.A.N in A.I.C. The analysis of models in this study points out dilemmas faced by practitioners using these counseling models, highlighting pivotal issues calling for sensitivity and possible integration while demonstrating the need for professional and cultural competency in diverse settings.

3.1.1 Chapter research question

This chapter will answer the research question in line with the objective of the study thus:

'What are some of the models/methods from other disciplines used for caring for and counseling people with faith healing and belief systems*?' (Interpretive Task)*

3.1.2 Logical structure of the chapter

Chapter 3 is the interpretive task according to Osmer that sough to identify and discuss core interdisciplinary models of care. Different Worldviews are discussed in this chapter since they have a lot of bearing on the strategies of care. The chapter established and presented the advantages, challenges and pointed out the relevance of select psychological and pastoral care and counseling models. The chapter highlighted and Linked views of Breed's and Louw's models to the African traditional counseling models that were used to help formulate an integrated model of pastoral care and counselling for people involved with faith healing within belief systems of L.I.C and M.C.A.N churches in Kenya

[55] This will be referred to as interdisciplinary models-Interdisciplinary models, which are the focus of this chapter, are approaches to counseling and psychotherapy used by a range of disciplines in helping people with concerns or challenges so that they can develop abilities to cope or solve problems they go through in their daily lives.

[56] Pastoral models for counseling selected for this study are 1. Breed's Biblical Pastoral Counseling model (Breed, 2015) and Louw's Four-Stage model of pastoral encounter (Louw, 2016).

3.1.3 Background to Interdisciplinary Models

Louw (2016:119) states that due to the plight for a holistic approach in help and healing, a theology of pastoral care cannot be exercised in isolation from the other human sciences. Both the psychological and social contexts are important resources for knowledge. He adds that psychology stresses the important dimension of listening and communication skills as well as the notion that the counselee has at his/her disposal an inner knowledge and therapeutic potential. Sociology, a social science, on the other hand, is said to put the issue of contextual and systemic-relational dimension of problems on the agenda of pastoral care. Further through pastoral theology, other sciences are made aware of the important aspect of spirituality and its correlation to religion in the process of helping and healing. This study contends that spirituality, as does the cognitive, conative, and affective, significantly affect meaningful human behaviour; hence making the multidisciplinary approach to care crucial.

There are various types of counseling and psychotherapeutic models used by all those who counsel people. Sule *et al*. (2017:1157-1166) attests to the fact that counsellors are familiar with well-known counseling theories, considered as major theories in the helping profession. Major models include psychoanalytic, Adlerian, existential, person centred, Gestalt, behaviour therapies, reality, Feminist, family systems and postmodern (Corey, 2017:62-521). Studies[57] have shown that Psychologists, marriage and family therapists, clergy, clinical therapists, nurses, and teachers guiding and counseling people in the helping professions use different models for assisting people in addressing their life challenges and concerns. Sociologically, Psychologically, and theologically oriented counseling models have unique underlying theories of human and personality development and psychotherapy. Each model is based on a school of thought, philosophy, or theoretical framework and has principles and unique ways that govern its working and therapeutic relationship between the counsellor, therapist, and the counselee. This is echoed by Kiriswa (2014:11) who says that 'every counseling technique is based on some philosophical assumptions or theoretical framework that provides the basic orientation and justification in the counseling practice.'

Differences and/or uniqueness of counseling models emanate from their philosophies, theories and

[57] Corey (2017:62-521) has psychotherapeutic models used by psychologists. Also, brief couple counseling could be used in couple counseling- (Gutierez, D., Carlson, R.G., Daire, P. & Young, EM. Evaluating treatment outcomes using the integrative couples counseling: A pilot study. Sage publishers. 2016. Pastoral care and counsellors could use – Four-Stage model (Louw, DJ. 2016:523-527) and Biblical counseling model (Breed, G.2015).

principles that guide therapeutic engagements between a counsellor and a counselee. One other distinguishing aspect between models is the question as to whether the approach they take to therapy is for instance either directive or non-directive. In Directive counseling models the therapist (counsellor) leads the therapeutic relationship, makes suggestions for solutions to the client's problems and plays the role of the expert in therapy. On the other hand, the non-directive counseling modes acknowledge the counselee as the expert of his or her life in the therapeutic relationship, allows the client to take the lead in therapy and the client suggests the course of action as the therapist facilitates the process.

Wolters (2008:64-65) says that the non-directive (ND) approach to counseling includes models that comprise listening to the client, and helping the client determine how to proceed. The ND approaches comprise the humanistic therapies that emphasize people's capacity to make rational choices and develop to their maximum potential. The concern and respect for others in a therapeutic relationship are extremely important themes. Examples of the humanistic theories include existential therapies, gestalt therapies and client-centred therapy.

The ND therapies are well-represented by Carl Rogers (1942) through person-centred therapy, of which the assumption is that human beings are rational beings, they are socialized, and are realistic. Rogers says that through positive regard, human beings are said to have the tendency to move towards realising their potential and self-actualisation. Similarly, positive and constructive relationships are seen to be extremely useful in therapy. A good example is the unconditional acceptance of clients in Person-centred Therapy (PCT). Furthermore, the direct approaches (DA) to counseling, according to Wolter (2008:64), Corey (2009:123) and Mukangi (2010:54), are models that are active, time-limited, present-centred and structural, provide advice, and are reassuring and clarifying. They include all cognitive behaviour therapies (BT) including CBT and rational emotive behaviour therapy (REBT). REBT as a counseling approach was introduced by Ellis (1955), and the basic assumption of this approach is that human beings are said to be both inherently rational and irrational, sensible and crazy (Eremie & Ubulom, 2016:43). Linkage among models of counseling is important. The ACA[58] (2014:10) emphasizes that there is a need for counseling teams in multidisciplinary helping fields to collaborate in their focus, respect for clients' needs, work as a team and complement one another in their relationships, which are critical to achieving caregiving goals. Miller *et al*. (2018:1) also suggest that primary healthcare is

[58] ACA as used in this study stands for 'American Counseling Association'

increasingly based on health care teams from different disciplines. Similarly, Babiker *et al*. (2014:9) adds that in delivering healthcare, effective teamwork can immediately affect patient safety and outcomes. Schottenfeld *et al.* (2016:2) say that team-based care offers many potential advantages, including expanded access to care; more efficient delivery of additional services that are essential to providing high-quality care such as patient education, behavioural health, self-management support, and care coordination.

Various models or approaches to counseling and psychotherapy practised both in the developed and developing worlds have a psychological, social or theological orientation. We also have models that combine psychology, sociology and theology such as pastoral care models or Biblical models.

The Psychological and Biblical/Christian models of counseling are independent and at the same time borrow from one another. This chapter looks at models of counseling (psychological) in developed countries, Biblical (Christian) models and traditional African models that are used in counseling. We will also discuss their relevance for counseling people with faith healing and belief systems. Since Worldviews play an important part in influencing the choice of the model to be used in helping people with counseling needs, we briefly highlight selected Worldviews. Also important in the models that we discuss in the sections that follow, are various aspects of divergence and convergence that appear in models during therapy. Key aspects of these models that are shaped by Worldviews include the role of cognitive factors in behaviour, experiential aspects in counseling and role of feelings, and finally putting plans into action and learning by doing (see Corey, 2017:8-9). This study utilises the African Counseling model, the Four-Stage model, and the Biblical Pastoral model to develop an integrated alternative model for pastoral care to help pastors and congregations in assisting people involved with faith healing within belief systems of L.I.C and M.C.A.N.

We briefly look at an overview of selected Worldviews and highlight their typologies before discussing models.

3.2 Worldviews – Meaning and typologies

There are different Worldviews and typologies. We looked at overviews of scientific Worldviews, Theistic Worldviews, Christian/biblical Worldviews, African Worldviews, post-modern Worldviews and Reformed Worldviews relevant to this study.

3.2.1 What a Worldview is

Worldview as a concept was coined by Emmanuel Kant (1724-1804), a German Philosopher originally as *weltanschauung*[59] in the German language. Kant used Worldview to refer to the power that influences people's perception of reality (Chemorion, 2014:1-2). According to Hiebert (2008:15) the concept *Worldview* refers to the '…fundamental cognitive, affective, and evaluative presuppositions a group of people make about the nature of things, and which they use to order their lives'. Furthermore, Worldviews learnt through everyday experiences are communally acquired in a context by a given people. For instance, there are several Worldviews such as Scientific, African, Religious, Biblical or Christian and postmodern, amongst others.

3.2.2 Worldviews and typologies

3.2.3 Scientific Worldviews

This study notes that there are scientists who do not subscribe to the secular Worldview. A more appropriate identification is secular Worldview or Scientism as a Worldview. We use scientific Worldview that is also known as secular Worldview. The scientific Worldview is a naturalistic Worldview. It is also identified as scientific humanist, metaphysical naturalist, and materialist. It holds the hypothesis that the natural world is a closed system, which means that nothing that does not form part of the natural world, does affect it. The Scientific Worldview (Cober,1989:6), also dubbed scientific modern Worldview, is a uniquely western (developed) phenomenon born out of intellectual tumult of the 16th to 18th centuries in Europe. The Scientific Worldview denies the existence of supernatural causes of natural phenomena, implying atheism, and instead relies on logic, mathematics, science, experience, the historical method, and trusted experts. This Worldview demonstrates trust in science and humanity and appreciates the connection between man and nature.

3.2.3.1Theistic – Religious Worldview

The religious Worldview, also theist or super naturalist, permits the use of deities and miracles as explanations for natural phenomena. Different religious groupings have different ways of explaining supernatural existence, natural phenomenon and relationships revolving around humanity, context and their deity or deities. In his discussion on theistic Worldviews, Chemorion

[59] See Ryken (2013:23-24) discussion on the historical part.

(2014:17-26) attests to the fact that theistic Worldviews subscribe to the existence of God or gods either as polytheism or monotheism. Polytheistic Worldviews refer to the worship of many gods (e.g ancient Canaanites, ancient Egyptian gods) whereas monotheistic Worldviews only worship one God (e.g Judaism, Christianity, and Islam). For instance, with reference to a monotheistic Worldview Chemorion (2014:14) says:

> In all monotheistic Worldviews, God is believed to be the Creator and originator of existence. The created universe has both spiritual and material dimensions...and humankind is viewed as the unique creation of God, relating to God, and knowing the revelation of God's truth through scriptures and observed created order.

3.2.4 Christian/Biblical Worldview

Christian Biblical Worldview which is a view that denotes how followers of Jesus Christ as their Lord and saviour see or experience the physical world or a world God has made and is redeeming by the power of the Gospel (Nickel, 2017:4). The believers who hold this view, use the lens of scripture, both Old and New Testament, to tell of the reality through their belief in God the Creator, revealed through his son Jesus Christ, the Lord and saviour by the power of the Holy Spirit of God.

3.2.5 African Worldview

The African Worldview has been defined and explained in detail by Chepkwony (2014:29-50):

> African Worldview refers to a way in which African peoples view and make sense of their world and how they relate to it. Similarly, African Worldview is the way Africans perceive the world in totality, thus what makes sense of all phenomena around them. It is the cultural construction of what a group of people perceive around them. More so, African worldview is a system of beliefs that provide African people with a mechanism to understand the world in which they live, and also helps to explain everyday occurrences and events; it constitutes beliefs, values and attitudes learned by each other from the time a person is born.

This is made possible through culturally influenced values that shape the understanding of the happenstances of a person and his/her context. The complexity of his Worldview is how it addresses the spiritual, social, and medicinal aspects (people, creation, Supreme Being divinities and ancestral spirits).

Kiriswa (2014:29), with reference to African societies and their Worldview, referred to the words of Parrinder (1962:113) and Mugambi and Kirima (1976:115-118), saying:

> Most African societies make no distinctions between the physical and the

> spiritual world, the sacred and secular, the mundane and the holy. Further, the African world and all it contains in its diverse dimensions is sacred, and is guided by a good God, also mysterious, powerful, and threatening forces of nature... which humanity have no control over.

3.2.6 Post-modern Worldview

Modernism signals a dialectical opposition to what is not functionally modern, namely tradition (Eysteinsson, 1990:8). Similarly, modernism strongly implies some kind of historical discontinuity; either a liberation from inherited patterns or at another extreme – deprivation and disinheritance (Eysteinsson & Liska, 2007:233).

Postmodernism expresses the fact that the things highly regarded in the modern Worldview are no longer given serious attention by the new generation; it replaces loss of faith in the achievements of modernity. Similarly, postmodern Worldview (PM) not only refutes standards of life that were seen as progress in the minds of modern people, but also rejects assumptions that western cultures are superior to other cultures, and moreover, the PM Worldview is at odds with standards and procedures as it considers no style better than the others (Chemorion, 2014:30-31).

3.2.7 Reformed Worldview within Practical theological studies

Reformed Worldview (RWV) lies in the point of departure that scripture serves as the primary source of interpretation (Wolters, 2005:7), and recognizes that man can draw conclusions regarding the invisible involvement of God[60] with visible reality by observing the patterns of reality embedded in the seen world in which we live in consequence of the divine consciousness seated in every person (Calvin, 1956:inst.1.5.2; Brink, 1999:159). RWV holds an all-comprehensive view of how God is involved in reality in His sovereignty based on the way inwhich one sees God's revelation of Himself in scripture (Van der Walt, 2009:372), as God reveals Himself through his word, and it is believed that 'anything that is contrary to scripture influences one's orientation with regard to understanding the world in a deforming, obscuring and corrupting manner.'[61] De Klerk and De Wet (2014:11-14) further say that the Reformed Worldview has a theocentric Worldview where God emerges as the one from whom, through whom and to whom

[60] 'When we speak of God, we know that this, real which we entertain is situated beyond human understanding. This real is a distant, invisible entity, whose power over thee human being is demonstrated in a roundabout manner, at times imperceptibly…'. God is a subject of speech and action in the structure of faith relationship. He is consciously focused on humans as an intentional subject. Humans direct themselves at him and they know him. God is the Holy one' (De Klerk & De Wet, 2014:11-12).

[61] Venter, 1995:182

all things are, who is involved in the contingent dimension of a trinitarian manner. Similarly, RWV holds the view that human life is a relationship of total dependence on the divine life (Van der Walt, 2009:372), as man is supposed to reflect the glory of God. The idea of *imago dei* (Image of God) that is a fundamental reformed theology, flows from Calvin's thinking and linking of revelational theology to ontology, soteriology, and ethics.

The Reformed Worldview based on the centrality of Scripture is of critical importance to this study. The researcher will, like in practical theological research, take on a unique dimension of a Worldview (the Reformed Worldview – RWV). This Worldview is needed to view the reality observed in the context of research, and investigate account for divine involvement in the visible reality of human actions in L.I.C and M.C.A.N. The researcher 'orientates herself about the manner in which this view departs from the normative source of Scripture and the means through which God reveals his involvement in this world' (De Klerk & De Wet, 2014:11).

3.3 Counseling and Psychotherapy Models

Counseling and psychotherapy models are those models (approaches) that are used in the helping processes by counsellors and therapists in their therapeutic relationships with clients in need of help. Similarly, counseling and psychotherapy are tools of edification, integration and intervention in helping the individual, couple and family to function well.

Based on the research results described in chapter 2 , the following extremely important conclusion can be drawn: Effective counseling and psychotherapy models for helping people in African contexts, utilising the western core values of autonomy, centred on individuality, self-reliance and independence by caregivers, ought to show sensitivity to African core values of communality exercised in African relatedness, interdependence, spirituality, and value systems.

It is extremely important to see how Western views of health, illness and sickness influence therapeutic encounters in the light of the African view of illness, health, and wellness. Therefore, understanding the philosophies and inclinations behind helping models is equally paramount and critical importance to this chapter.

3.3.1 Biomedical Approach (BPS)

Biomedical, bio-psychosocial, or biopsychosocial and spiritual models show a progressive trend of models used in healthcare. Chemorion (2009:56-61) states that the original biomedical model (BMM) which has been dominant in the field of medicine, guided health practitioners in

acknowledging biological explanations for ill health. The biological model to health and sickness is dominant in medicine in the process of curing and healing in today's world… the medical world places strong emphasis on biological and organic approaches to illness influenced by bacteria, epidemiological, mechanic, cellular and psychosomatic theories (Louw, 2008:36-37). The BMM model is reductionist as it ignores that both psychological and social factors contribute to ill health. With time, dissatisfaction (Louw, 2008:38-39) of the singular causal understanding led to recognition of the social factors as equally contributing to ill health. This was strongly echoed by WHO[62] (1998, 2006) that considered the importance of spirituality in healthcare, and this saw the model (BMM) evolve into bio-psycho-social and later to include spirituality factors that affect healthcare (also see Lakhan, 2006:2).

Chemorion (2009:56-60), Louw (2008:37), Lakhan (2006:1-2.) and Twaddle and Hessler (1977:98) have discussed in detail the advantages but also the challenges of the biomedical model in healthcare.

3.3.2 Psychological model

The Psychological model is a model of spirituality care that involves the use of psychological techniques in pastoral and therapeutic encounters. Psychology has been defined as the 'science of measuring mental things that do not exist' (Curt, 1994:241). The Psychological model, when used, will provide insight into understanding personal growth in spirituality including spiritual maturing – or growth (Gillispie, 2002:119). Similarly, the psychological model of spirituality care broadens and deepens our understanding of the encounter between human beings and the divine. It is also notable that through the psychological model, psychological perspectives assist caregivers in understanding, accessing and assessing human experiences of pain, anger, grief and solitude.

3.3.3 Psychoanalytic Therapy

This theory (Psychoanalytic model) was developed by Sigmund Freud, an Austrian neurologist born in 1856 (Jacobson, 2013:1). Psychoanalysis refers to a theory of normal and abnormal development of the mind, a system of therapy developed to apply treatment based on the theory, a profession that administers the therapy and a method of research (Ronch *et al*., 1994:5). Freud's psychoanalytic system is a model of personality development and an approach to psychotherapy. He (Freud) gave psychotherapy a new look and new horizons, calling attention to psychodynamic

[62] WHO stands for World Health Organization.

factors that motivate behaviour, focusing on the role of the unconscious, and developing the first therapeutic procedures for understanding and modifying the structure of one's basic character (Corey, 2009:60). In the basic psychoanalytic concepts and practices, Freud viewed human nature as determined by irrational forces, unconscious motivation, and biological and instinctual drives as they evolve in the psychosexual stages of human development in 0-6 years. Further, the psychoanalytic view sees personality as consisting of three systems; thus, the ID, EGO, and the super EGO. The ID represents the biological component, the EGO is the psychological component, and the Super EGO is the social component (Corey, 2009:60-61).

Corey (2009:62-63) further adds that Freud's concepts of unconscious and consciousness are valuable as they ... are the keys to understanding behaviour and problems of personality. Similarly, anxiety, which covers reality, moral and neurotic, is a feeling of dread that results from repressed feelings, memories, desires and experiences that emerge from the surface of awareness and is central to the psychoanalytic approach. Equally important in this model is Ego-defence Mechanisms that help a person to cope with anxiety and prevent one's Ego from being overwhelmed.

The therapeutic process of the psychoanalytic model has its two goals, thus to '…make the unconscious conscious and to strengthen the ego so that behaviour is based more on reality and less on instinctual cravings or irrational guilt' (Corey, 2009:69). Through this model, as soon as the counsellor (therapist) establishes a working relationship with the counselee, he/she listens a lot while interpreting. This is done while the therapist engages therapy by maintaining neutrality. In doing this, transfers of feelings originally experienced in an early relationship are transferred to other important people in the client's present environment. Analysis in this model helps the client acquire the freedom to love, work and play. Other functions include assisting the counselee gain self-awareness, honesty and effective personal relationships.

Applying this model also helps clients deal with anxiety in a realistic manner and gain control over impulsive and irrational behaviour. Kiriswa (2014.13) adds that Psychoanalysis has as its goal to make the unconscious conscious, to reconstruct the basic personality, to strengthen the ego and to make the client aware of the relationship between the current behaviours and the repressed unconscious realities. Furthermore, Kiriswa (2014:13) summarises techniques used by psychoanalysis such as interpretation, dream analysis, free association, analysis of resistance and analysis of transference that are designed to help clients gain access to unconscious conflicts. Using these techniques lead to gaining insight and developing ability to resolve conflicts; hence

influencing positive personality change.

3.3.4 Behavioural Therapy

Behavioural therapy focuses on observable behaviour and current determinants of human behaviour. The Behavioural model of counseling and psychotherapy was pioneered and developed by BF Skinner (1904-1990) and Albert Bandura[63] Skinner, who is also called the father of Behavioural Approach, championed for radical behaviourism which emphasises the effects of the environment on human behaviour. Skinner denied that humans have a free will, and that feelings and thoughts cause any human action. He rather stressed that cause and effect linked between objective, observable environment conditions and behaviour. He was also interested in concepts of reinforcement of human behaviour.

3.3.4.1 Rational Emotive Behaviour Therapy (REBT)

Rational Emotive Therapy was developed by Albert Ellis who was a psychologist trained in psychoanalysis in the mid-1950s. Ellis held the belief that clients responded well to therapy and got better when they changed the way they thought about themselves, their problems and the world. Rational Emotive Therapy was originally called Rational Therapy and then changed to Rational Emotive Therapy until the 1990s when it was renamed Rational Emotive Behaviour Therapy (REBT). It is one of the cognitive behaviour therapies among them (CT) – Cognitive Therapy.This is echoed by Kiriswa (2014:16) who says, 'Albert Ellis' Rational Emotive Behaviour Theory is a combination of cognitive and behavioural factors''.

REBT's hypothesis is that human emotions mainly stem from beliefs, evaluations, interpretations, and reactions to life situations (Corey, 2009:276). Similarly, REBT believes that humanity has the tendency of increasing desires and preferences... and also important is the fact that blame is at the core of emotional disturbances, and therefore to heal, we need to stop blaming ourselves and others, and instead learn to accept ourselves despite our imperfections.

Corey (2017:8) says that REBT and CBT (Cognitive Behaviour Therapy) gave a high profile to the importance of learning how to confront inaccurate and self-automatic irrational thoughts that

[63] Bandura, a contemporary of Skinner, born in 1925 pioneered social modelling and demonstrated that modelling is a powerful process that explains different forms of learning among humans. He further explored the social learning theory and the prominent role of observational learning and social modelling in human motivation, thought and action.

contribute to behaviour problems. He adds that the REBT and CBT models are used in therapy to assist clients in modifying their inaccurate and self-defeating assumptions so that clients can develop alternative acting patterns (based on change in cognition).

Louw (2016:429) says that the focus of the REBT model is the irrational thinking and the impact of must-messages (absolute categories) on self-understanding and self-evaluation. The intention of this model is to emphasise the crucial role of maladaptive, irrational thinking in the present. REBT intends to probe into the maladaptive schemas set in the human mind that lead to emotional difficulties and hamper meaningful orientation.

Key assumptions in this model of counseling allude that people condition themselves to feel disturbed, rather than being conditioned by factors from outside. Also, it is assumed that people have biological tendencies not to think right and to disturb themselves. Similarly, it is assumed that humans invent disturbing beliefs, and that people have the capacity to change their cognitive, emotive, and behavioural processes. According to the REBT model, people can make choices to react differently and refuse to be disturbed. Likewise, humans are self-evaluating and self-sustaining and emotional disturbances in humans occur when preferences are turned into dire needs.

REBT basically assumes that people contribute to their own psychological problems as well as to specific symptoms by the way they interpret events and situations in their lives. Similarly, REBT assumes that cognitions, emotions and behaviours interact significantly and have a reciprocal cause-effect relationship. Similarly, people, according to REBT, are born with the potential for either straight or crooked thinking (rational or irrational). REBT's view of human nature is that, in as much as people have the tendency for self-preservation, happiness, loving, thinking and verbalizing, communion with others, growth and self-actualization, they also have the inclination for self-destruction, avoidance of thought, procrastination, endless repetition of mistakes, superstition, intolerance, perfectionism and self-blame, and avoidance of actualizing growth potentials.

REBT's contributions to therapy are enormous. For instance, the approach affords clients an opportunity of changing the presenting problem, and many other related problems faced currently in their lives, or future problems clients might experience. Clients also learn skills that give them tools to identify and dispute irrational beliefs, as they learn to replace ineffective ways of thinking with the rational cognitions. Furthermore, through REBT, promoting rational cognitions leads to

clients changing their past emotional reactions to troubling situations. REBT grants clients the ability to accept themselves as creatures who will continue to make mistakes yet learn to live more at peace with themselves. Similarly, through REBT, therapists have specific tasks such as first showing the client how they have incorporated irrational beliefs and faulty thinking in the conversation (for instance by using demanding words such as 'must'. 'should', 'ought to' and 'awful'). Finally, through REBT, therapists keep checking illogical and unrealistic thought patterns of clients to help them change. In doing so, clients modify their thinking and minimize their irrational ideas that contribute to conflicts. Eremie and Ubulom (2016:45) contend that the role of the therapist is active, directive and teaching oriented. The therapist is said to assist clients in learning to redirect self-defeating irrational thinking to rational thinking.

REBT is useful in counseling challenged people with faith healing tendencies within belief systems, since through this model, the counsellor can work with pastors and congregations to clearly identify events in their lives. This will help the challenged people to better see the indoctrinated irrational thoughts that are repeated from the time members joined the church, that led to dysfunctional behaviour. More so, pastors and congregations will understand the consequences of the irrational beliefs of troubled people in congregations and be taught and directed towards re-looking at the beliefs they hold surrounding the troubles they have been through in their lives. Pastors and congregations later help the troubled persons to change; hence minimizing the self-defeating irrational ideas that bring conflicts. This will further bring a clear picture of the expected outcome in behaviour afterwards. For instance, some behaviours among them include trusting in the total healing of a human deity (Jehovah in L.I.C), acceptance of poverty as a way of life (poor children of God), treatment of mental health through sacrifices on the altar, and touching the head of the lamb when making animal sacrifices as a way of removal of sins.

3.3.5 Person-Centred Model (PCT)

The Person-centred approach to therapy (PCT) is generally viewed as part of third-force or humanistic therapy following the psychodynamic tradition and psychoanalysis schools and behavioural tradition. As a model to therapy, PCT offers a comprehensive, coherent, and holistic approach to human life and concerns (Tudor *et al*., 2004:3-22). Elsewhere a Person-centred model of therapy (PCT) is seen as a psychological type of counseling model that is existentially oriented and has as its greatest concerns, therapeutic relationships and how the client experiences life, rather than diagnosis and cause of the problems (Mandy & Joanne, 2016:129).

The PCT model, which is also regarded as Rogerian therapy or person-centred Psychotherapy, is a form of talk therapy developed by Carl Rogers from the 1940s up until the 1950s. This model of counseling proposes to increase a person's (client's) feelings of self-worth, reduce the level of incongruence between the ideal and actual self, and help a counselee become more fully human. Rogers based this theory on the belief in the positive nature of human beings.

Wilkins (2003:7-21) adds that in as much as PCT emphasises the person, it throws the responsibility upon the client, and attention is directed away from the need. Similarly, the PCT model values the autonomy and self-determination of the client and does not look at the therapist as the expert but at the client as an expert. The PCT model promotes holism in therapy.

Mearns, Thorne, and McLeod (2013:52) argue that in person-centred counseling, the therapeutic alliance is not enough, since working at relational depth is more effective. To achieve relational depth, the core conditions need to be offered in such a manner that each enhances the effect of the other, allowing the client to experience empathy, coupled with a feeling of acceptance, and to believe that these are offered in a congruent manner. Person-centred counsellors are existentially oriented, concerning themselves with how the client experiences life rather than diagnosis and cause. Their relationship with the client is of primary importance, and this facilitates therapeutic change (Rogers, 1951, 1967).

Rogers[64] strongly held that people have much inner strength that could be used to promote self-understanding and change of attitude and behaviour:

> It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes, and self-directed behaviour – and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided (Rogers, 1986).

The PCT model is anchored in three core conditions: congruence, empathic understanding, and unconditional positive regard. Congruence refers to truthfulness or genuineness, empathic understanding involves acceptance and support of a person during therapy, regardless of how the person (counselee) is or what he/she says or does. Empathy in this model refers to accurate understanding of someone's feelings or actions or stepping into the shoes of someone else. It is the three above-mentioned core conditions that make possible a rapport to be established in a

[64] Rogers, C. 1990. A client -centred/person centred approach to therapy. In H. Kirschenbaum and V.L Henderson (eds). The Carl Rogers Reader. Constable. London. pp. 135. (Original work published in 1986).

therapeutic conversation. In a nutshell, the core conditions refer to: 1) genuinely understanding the client, 2) genuinely and unconditionally accepting and caring about the client, and 3) genuinely being oneself as an effective and dependable counsellor in the therapeutic relationship.

The person-centred approach holds that the client holds the key to his/her recovery and not the therapist/counsellor. Hence the counsellor has a duty to offer the client a therapeutic relationship to openly discover and test his/her own reality. This is achieved when counsellors/therapists facilitate the core conditions; thus 1) unconditional positive regard, 2) warmth, and positive accepting attitude without passing evaluative or moral judgement and 3) accurate empathy by means of which the counsellor accurately understands the client's world through skilled or active listening. This PCT model has also been discussed by Kiriswa (2014:14-16).

This model of counseling holds that each person exists in a private world that is at the centre of his/her life. Furthermore, the model suggests that a person's most basic struggle in the world is self-actualization. The counselee is seen as reacting to situations based on self-concept and one's view of the world. This model therefore focuses on self-actualization and positive forces of the client such as skills and abilities clients applied in an attempt to deal with a similar problem in the past.

In the person-centred approach, the focus is on the affective dimension with less emphasis on the spiritual dimension. When PCT is applied, it may conflict with a client from a faith community within a belief system, since faith healing cannot be affected. Louw (2016:124-125) states that the human sin, which is interpreted as irrationality or emotional obstruction, stands in the way of self-assertion; hence compromising the normative component.

3.3.6 Egan, the Skilled Helper Model (three-stage model)

The Egan Model is a model used in counseling to achieve change and to empower counselees to manage their own problems more effectively and to develop unused potentials more fully. This model comprises 3 stages. Stage 1. Exploring – what is going on? Stage 2. Challenging – What do I want instead? Stage 3. Action planning – How might I achieve what I want? The sequence of Exploring-Understanding-Action planning steps is followed in counseling as was developed by Egan[65]. A detailed introductory exploration of the model has been done by Nelson (2007:1) who

[65] See Egan, G.2002 The skilled helper. A problem management and opportunity development approach of helping people.7th (ed). Pacific Grove, CA: Brooks Cole; Egan G.2006.Essentials of skilled helping: managing problems, developing opportunities. Pacific Grove, CA: Brooks Cole.

explains:

> Gerard Egan's Skilled Helper Model of eclectically based counseling provides a structured and solution focused basis for counsellors, psychotherapists, and hypnotherapists. It is a three-stage model in which each stage consists of specific skills that the therapist uses to help the client move forward.

This Skilled Helper model is useful in assisting people in managing and developing opportunities for problem solving and growth. Counseling skills[66] in the PCT model helps the counsellor to work with the client from stage one through to the third stage. The Skilled Helper model uses eclectically based counseling, and it provides a structured and solution-focused framework for counsellors/therapists (Egan, 1998:7-8) through the Egan model, and particularly by employing the core conditions (see Rogerian – PCT/CCT model core conditions) of genuineness, respect and empathy.

- People (counselees) become better at helping themselves in their everyday lives.
- Emphasis is placed on empowerment of people (counselees) so they can manage their own problems more effectively.
- The person's (counselee's) own agenda stands central in the relationship between the counsellor and the counselee.
- The model moves the person (counselee) towards action, leading to outcomes that they choose and value.
- The client's active interpretation of his/her world, giving meaning to actions, events, and situations.
- The counselee develops the ability to face and overcome challenges.
- Exploration of problem issues and seeking new opportunities.
- Enhances setting own (client's) goals.
- Influences counselee to become active in initiating his/her new behaviour

[66] These counseling skills are very important in the three stages of the Egan model: Open ended questions, clarifying, summarizing, challenging, active listening, responding, empathy, reframing, brainstorming, generating strategies, alternative frames of reference, exploring, teaching, silence, focusing, structuring, self- disclosure, immediacy timing and pacing, evaluating, goal setting and divergent thinking (Egan,1994).

- Prepares counselee to develop skills to solve current and future problems.

- Increases counsellor awareness of client's non-verbal communication through effective listening (SOLER), and empathy.

From the above we learn to know the main goals of the model, as suggested by Egan (1998:7-8), to be majorly:

> To help people/clients manage their problems and live more effectively, develop unused potentialities/opportunities more fully, enable clients to become better at helping themselves in their everyday lives and to achieve lasting change in the client/counselee's life in therapy.

The Egan Three-Stage Model utilizes three stages: the current scenario (stage 1), the preferred scenario (stage 2), and the way forward scenario (stage 3) as shown in table 3-1 below.

Table 3-1: Stages of the Egan Model adapted from Egan

Stage 1. Current scenario	Stage 2. Preferred scenario	Stage3. Way forward - Action strategies
What is going on? – the story What is really going on? Blind spots Focusing/prioritizing – leverage	What do I want instead? Possibilities Smart Goals – change agenda Action-valued outcomes – check goals(commitment)	How many ways are there? Possible actions What will work for me? – best fit What Next/when? – Plan
Building and exploring a helping relationship – help identify and clarify problem	Gain new understanding, see new perspectives – assist client in creating a better future	Help client develop helping strategies getting there – -assist client in solving his/her problems better

3.3.7 African traditional Counseling and Wellness

Africans have always had their own approaches to counseling[67], and this has been found to be very resourceful. The helping ways among African communities are shaped by Worldviews. Chemorion (2014:12) points out that ideas of traditional African Worldviews are contained in narratives, proverbs, wise sayings, and African rituals performed by specialists such as priests, rainmakers, and (other) officiating leaders in communities. Furthermore, the Traditional Worldview is part of

[67] Traditional African Counseling is unique as it uses many forms, and it affects all aspects of life. This approach (African traditional counseling) is used to assist (African) people in difficult circumstances experiencing among others, loss, anxiety over childlessness, calamity, mental disturbance, and conflicting situations.

life, and it is reflected in every activity in which one engages. Those who are involved in caregiving in Africa therefore use a Worldview to offer holistic care to those in need. Louw (2016:24) states that in research on the contextualization of care giving within African settings, several voices that have advocated for an Afro-centric approach to counseling that captures the hope for healing within cultural contexts become important. Edwards and Edwards (2011:8) have said that healing is deeply rooted in the physical, emotional and spiritual aspects of being and is inextricably linked to religion or belief systems. Within an African perspective, the human being cannot be understood separate from cultural issues and values, as humans are embedded in culture.

Each African community has from time immemorial had communally defined persons who would talk people through struggling with some issues. African traditional counseling is a directive form of counseling. Those involved in counseling range from family heads, women leaders, friends, specialists such as diviners, herbalists, and prophets. In this approach, the counsellor, who has the expertise passed over to him/her orally and through experience, gives advice using 'culturally sensitive methods, insights and values drawn from rich African wisdom and cultural heritage. All these are informed by African Worldview and philosophy of life' (Kiriswa, 2014:31). The African Worldview impacts how people on the African continent see; not only what goes on around them

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but understand and make sense of health/illness and wellness dynamics and the help they need (counseling).

African indigenous counseling is an approach used to support African people with challenges – social, psychological, or physical – and the approach is based on the 'African Worldview'. In this view, most African societies draw no distinction between what is considered physical or spiritual world, sacred or secular, mundane or holy (Kiriswa, 2014:29). Mugambi (1976:115-118) reiterates that the world and all that is in it is sacred, guided by a good God, also by mysterious and powerful and threatening forces of nature over which human beings have no control. In the same vein, Van Dyk (2008:201) says that during disease prevention in traditional Africa, there are certain perceptions of illness; thus:

> When bad things happen, traditional [African] thought does not simply attribute it to luck, chance, or fate, instead, there is belief that every illness is directed by an intention and a specific cause. In order to fight the illness, it is therefore necessary to identify, uproot, punish, eliminate, and neutralise the cause, and the agent of the cause and intention.

From the above sentiments, the African theory of causation has an important hand in intervention

strategies for care, healing, and wellness. No one falls ill by himself or herself. No one dies without a cause, and if it is a human force, spiritual force or communal force, attempts to address the challenge must focus on the cause and put the interests of the community at heart. In the African Worldview of illness, a distinction is drawn between physical or mental and psychological illnesses. The cause behind the illnesses is attributed to broken relationships or certain forces with mystical powers such as sorcery or witchcraft of evil people. Here the ill is seen to have offended God, ancestors, or spirits. The illnesses are treated by several means, namely medicine, rituals, exorcisms, and sacrifices. This has prompted Louw (2008:157) to say that:

> Life for the African is integral whole of cosmic and social events...when one breaks the moral codes of society, the ties between oneself and the society are broken. Recovery and cure thus … acquire a new dimension: it is not the person who must be cured in the first place, but the broken ties and relationships.

Broken relationships affecting the individual in community, leading to illnesses, also calls for healing strategies so as to become cognisant of the fact that relational therapeutic approaches are needed since they promote holistic and communal healing.

Gichinga (2007:9) maintains that 'to have diagnosis of illnesses with supernatural aetiology, realities that many Africans believe in, it is imperative to seek explanations and interventions that are cognisant of these realities. The illnesses lead to either intrapersonal, interpersonal, or communal crises and hopelessness and hence provoking the search for much needed healing from known family and or community specialists. Diviners, who were men or women were called upon to assess and give a prescription for the condition'. Here the diviner reveals agents of the illness and gives a proper prescription for the cure and protection of the patient. Diagnosis involved naming of the causal factor and remedies such as who had caused illness and charms, herbal medicine. Rituals to be performed were also identified, and supportive counseling to assure the afflicted person's restoration to communal wellness.

Similarly, Berinyuu (1998:5) in his book on pastoral care to the sick in Africa added his voice to sentiments mentioned above by saying:

> In Africa, there is no division and differentiation between the animate and inanimate, between the spirit and matter, between living and non-living, dead, and living, physical and metaphysical, secular and sacred, the body and the spirit.

Therefore, an approach to counseling in the African context should take cognisance of the holistic nature of the African view of life and the quest for wellness of people and everything in their world.

Counseling in Africa is holistic (non-segmented) as it addresses psychological, social, religious economic, cultural, political and environmental issues disturbing the African peoples. In Africa, counseling is done using an African approach relevant to African peoples as it addresses the African peoples' Worldviews and contextual issues raised by people in each community. This counseling is done to a homogenous group of people. To be precise, the type of counseling given in Africa takes the form of advice giving, wisdom sharing, material sharing, emotional and psychological support – hospitality, ritual officiating and sacrifices, home caregiving, traditional medicine counseling and consulting specialists. The counseling support is given by a member of a given community to another member of the same community either as family member, elder or specialist (Gichinga, 2007:9).

Counseling in traditional Africa is offered by a wide range of people who are not necessarily professionals. Untrained counsellors who have not gone for formal training; thus, following the less modern western approaches voluntarily counsel or are approached by those challenged needing assistance. The ability to give counsel to a person needing care and support in Africa is dependent on one's ability to give counsel freely, one who is available, one willing to give both material and non-material support, and one who can tap from his or her experience to support another person going through a similar experience (Gichinga, 2007:9).

The counsellor is a lay person who has acquired the skills of counseling through socialization within a family or community and one who has the experience in dealing with issues of others who are troubled in one way or another. Traditional counsellors have two ways of caring for the troubled; they do however not sit in posh offices to wait for disturbed people to go to them. Instead, troubled people, who are struggling but still in charge of their lives, could visit them within the community, or the specialists visit the troubled in their homes. However, there are some specialists who are also consulted to give counseling on difficult issues contributing to the disturbances of the person in need of counsel. In this case, the troubled is escorted by a member of the family to check the specialist for consultation, care, support and advice needed to address the situation. Hence challenged people in typical African community settings receive care and assistance from the following:

- Immediate Family members, parents, elder siblings;
- Extended family – aunt, uncle, cousin, grandparents;

- Clan leaders – elders – male/female;
- Entire community – young / old, male / female, specialists and ordinary people;
- Diviners;
- Witch doctors; and
- Herbalists

3.3.7.1 African traditional counseling and wellness model

The African traditional counseling and wellness model also plays a key role in models of caregiving in Africa. Many authors advocate for Afrocentric approaches in caregiving in Africa. Louw (2016:24) states that contextualization of caregiving within the African setting captures the hope of healing people within the cultural setting. For instance, in L.I.C and M.C.A.N there is optimism of attaining healing, wholeness and wellness as understood within their own communities.

African indigenous counseling is used to support African people with social, psychological, or physical challenges based on the African Worldview, and their philosophy of life is holistic. Help and advice given when following this method is based on culture, values, and wisdom. Pastoral caregivers do not differentiate between what is considered physical and spiritual world, sacred or secular, mundane (Kiriswa, 2014.29). Those involved in care use culturally sensitive methods, insights and values drawn from African wisdom and cultural heritage (Kiriswa, 2014:31). This method applies many forms and addresses many aspects of life since it is holistic in offering assistance to those in need. Healing in this approach is not only rooted in the physical, emotional, and spiritual aspects of being but also in the religion and beliefs of a people (Edwards & Edwards, 2011:8). Caregivers make use of the available resources for care and support, exploiting connectedness as key ingredient for care and wellness. Further healing in the church is holistic and emphasizes the mystical and spiritual and physical understanding of health and disease (Mwaura, 1994:63), and restoration of wholeness for individuals and communities (Ndung'u, 2009:87-104), and provision of psychological wellbeing (Mtetwa, 2009:119-131). From this model, this current study finds the following principles useful in healing:

- Sense of community and available resources – values, wisdom, hospitality, material, and relationships as support systems;

- Healing, restoration and wellness;
- Psychological wellbeing of care-seekers;
- Provides for visitation – caregivers to visit clients or vice-versa;
- Uses non-segmented approach to care (holistic); and
- Has relevance – it is contextual and ensures communal healing and hope.

This model will be instrumental in contributing to the guidelines alongside the Four-Stage model, and Biblical Pastoral model that will make it possible to care for care-seekers from the African community whose view of the world cherishes the person within the community, the use of community resources and embraces the healing of the person and relationships in community.

3.3.8 Four-Stage model in the pastoral encounter

The Four-Stage model of counseling proposed by Louw (2016:522-528) is a model with a structure for counseling that helps caregivers track and remain in touch with the process of counseling. The Four-Stage model helps gain insight into a therapeutic conversation and connects different aspects of narrative to components such as networking and relationships in the process of interpretation and understanding.

The four stages are: 1) Direction to future planning (affective) involving trust-building and sharing. When giving care to people from A.I.Cs with challenges connected to their faith healing within belief systems, the care giver at stage 1 of 4, namely building trust and sharing, makes contact and builds a trusting relationship to assist them understand themselves within the experiential world of challenges. Safe space is created for self-disclosures of happy, dramatic, tragic, ironic or comical stories through caregiver's unconditional love that communicates acceptance of the care-seeker; and 2) consideration of options (cognitive – reflection clarification, problem identification, interpretation.

At this stage people with troubles connected to their faith healing tendencies within belief systems in L.I.C and M.C.A.N are assisted by the caregiver to integrate facts, and to reflect on the meaning of events at a cognitive level. In a sensitive and caring manner, different teams (interdisciplinary) from A.I.Cs involved in caregiving relay important information related to the situation of the care

seeker; 3) Challenge of decision making (Conative) – motivation, encouragement, responsibility, and the setting goals. Personal responsibility of a care-seeker experiencing challenges related to faith healing within belief systems is assisted by the caregiver to be actively involved in their situation and healing process, to explore different possible options, and to make appropriate decisions. The care-seeker is encouraged to formulate goals that involve action; and 4) Goal setting (spiritual) – integration and meaning giving (hope), belief and resilience (spiritual dimension). The four stages of this model overlap one another, and merge in the process of a therapeutic encounter (talk-therapy). The focus in this stage is the caregiver's ability to impart meaning, and care-seeker's possibility of receiving meaning, facilitation of wisdom and maintaining faith by applying spiritual resources; thus scripture, diakonia (service), prayer, holy communion, fellowship, and liturgical resources.

Caregivers to people from A.I.C's faith healing within belief systems use existing belief systems, norms, values, convictions, and philosophies at this spiritual level to impart meaning, and facilitate wisdom and maturity in faith. Caregivers help the care-seeker from A.I.Cs to see the bigger picture, and to start linking found initiatives to trusted sources that can provide stability, encouragement, sustainability and resilience (Louw, 2016:523-527).

The Four-Stage model (Louw, 2016:527) presented below is applicable both to believers and non-believers, given that the principles which are implied at the stages suit all humans in any cultural setting. Caregivers can, by applying this model support troubled people with the faith healing tendencies within belief systems in African instituted churches.

Table 3-2: Four-Stage Model in pastoral encounter

	Stage 1: Affective	Stage 2: Cognitive	Stage 3: Conative	Stage 4: Spiritual
Personal impact	Self-insight and Sharing Disclosure	Self-interrogation Comprehension Networking	Active involvement and taking responsibility. Exploring different options decision making.	Meaning giving and resilience
Personal challenge and critical hermeneutical assessment	Self-understanding	Problem identification Acceptance of situation	Action/programme Goal setting Future scenarios	Appropriateness of moral framework Character of Worldview Efficiency of belief systems (God-image)
Caregiving skills	Listening Empathy Inter-pathy Understanding Sensitivity Compassion	Knowledge of theodicy Summary of facts Valid information Story analysis Disputation of irrational concepts Prolong into schemata of interpretation	Assistance in formulating objectives Goal facilitation, motivation partaking in rituals	Significance and identifying signals of transcendence Encouragement and hope giving Seeing the bigger picture (synthesis) Organic use of external resources (Biblical counseling, prayer, serving sacraments

	Stage 1: Affective	Stage 2: Cognitive	Stage 3: Conative	Stage 4: Spiritual
Objective	Building trust Relationship Understanding and sensitivity	Building new perspective Vision Insights Reframing Repurposing	Cooperation Purposeful behaviour Systemic interaction Networking of ideas	Grown in faith Maturity in faith Receiving meaning Encouragement Generating hope Integration
Core components	Emotion Unconditional love Systemic approach	Reason, paradigms and ideamatic realm pastoral style and attitude Thought and wisdom Philosophical counseling	Will responsibly support network Family and friends Fellowship	Hope and faith Religious and cultural value and norms Faithful promises Promissiotherapy
Summary	Feel	Think	Do	Believe/Trust

(Adapted from Louw. 2016:528)

3.3.9 Biblical Pastoral Model

A Biblical counseling model proposed by Breed (2015) centres on believers' relationships with God and convictions[68] they have formed from experiences in their lives. Believers' convictions are explored to identify them as either true or false, after which believers' false convictions (lies) are then addressed with God's eternal truths as found in scripture (Pretorius, 2017:192). The theoretical framework for the Biblical pastoral counseling model by Breed is anchored in: 1) God the Father; 2) the work of Christ; and 3) the work of the Holy Spirit. Breed's model covers godly relationships, the fall of man, man's attempt to cure a God-shaped cavity and formation of habits (Nicol, 2018:12-13, Pretorius, 2017:198-204). The essential foundational underpinnings of Breed's Biblical Pastoral model revolve around: Conversation – It holds that a human being continually converses with him/herself, with situations in life, with other people and with God. This conversation takes place in the mind on the basis of his/her convictions and to make sense of life. The outcome of the conversation in a human being's mind determines reactions to life situations.

[68] Convictions are what people hold strongly and believe in, are formed either by repeated behaviour or life traumas. They are applied many times in life situations even when the ideas are not based on truth. They sometimes are incorrect ideas, not based on any reality but impact decisions, actions and or feelings. These convictions eventually determine one's character, charting a way for one's ultimate end (Breed, 2015; Pretorius, 2017:196; Nicol, 2018:12).

Breed's (2015) model is based on the principles of: 1) Godly relations – here it is believed God created humans to live in relation with God, with one another, and with creation to be characterised by trust, honesty, and love. In this relationship, man experiences love and providence; 2) Attempts to cure pain and fill the void from the inside: The human feeling of emptiness is real and when it sets in with pain and frustration, a person attempts to fill the gap due to the desires one has to cure the pain. Repeated experiences of use of unhealthy temporary solutions such as anger, procrastination, and inflicting pain on oneself repeatedly becomes habitual or addictive and makes a person to numb and make it usual. The person then exhibits habits based on either true or false convictions at the back of one's mind (sub-conscious). Breed observes that false convictions only offer temporary relief to problems and the risk with this is enslavement of the person in the process (Breed, 2015). Breed links this human situation to the context of Jer. 2:13 when people forsake God and his grace, by turning to their own unhelpful broken and wrong sources of solutions while God is available to them.

God shaped cavity – Because of the brokenness of human beings, their relationships and societies, all people are hurting in one way or another. In essence this hurt comes from the broken relationship with God and not living from the grace of God. This creates a cavity in a person, which they try to fill with something other than God's grace. Breed (2015) explains that this is short-term false relief based on false convictions that leave humans unfulfilled, and without abundant life. Hence it is only the triune God through his grace that can provide a person with permanent relief (see Isa.55:1); 4) Formation of bad habits – repeatedly used convictions in a person create habits that make one to respond semi-automatically to a certain trigger. False conviction then determines one's behaviour, which can lead to further problems and more hurt.

Phases of Breed's(2015) Model that are in line with Osmer's model are as follows (I Adapted from Pretorius, 2017:205):

1. Descriptive empirical task of priestly listening to discover 'what is going on'? Relationship building and data gathering

2. Interpretive task of sagely wisdom to understand 'why this is going on' Determine the false or true convictions

Diagnostic phase

3. Normative Task of prophetic discernment to figure out 'what ought to be going on'? What are the truths of God by which the Coram Deo false convictions should be replaced.

Bringing a person before God

Coram Deo

4.Pragmatic task of servant leadership in addressing the question as to 'how we might respond' – seeking practical solutions based on the Word of God

Breed's Model utilizes four phases, focusing on: relationship building and data gathering (phase 1), Engaging scriptural truths (phase 2), obedience and perseverance (phase3), and support and follow-up (phase 4) as shown in the following graphic presentation below.

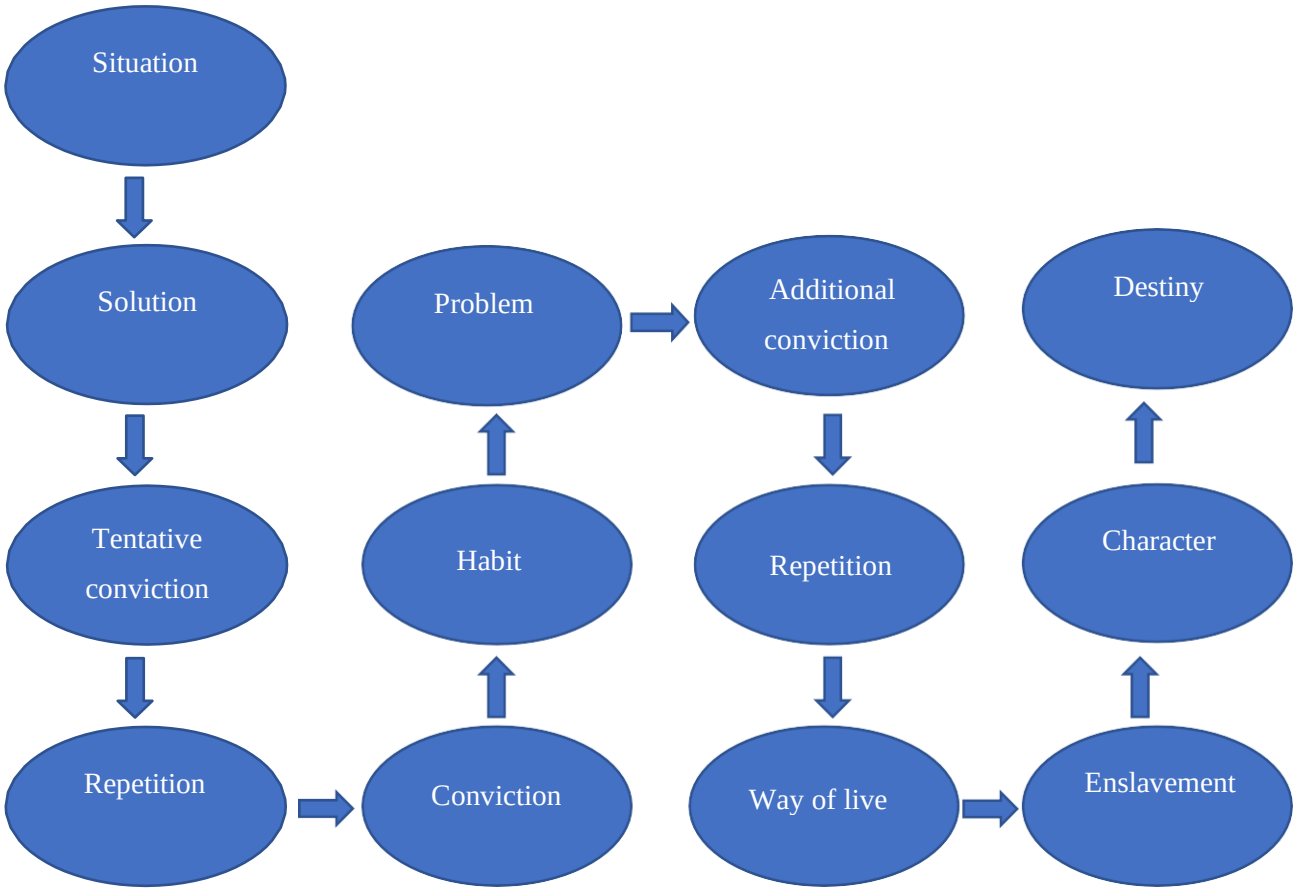


Figure 3-2 Graphic presentation of Breed's Model – human conversation

Breed's theoretical framework for a model for pastoral counseling consists of the following four phases:

Phase 1. Relationship building and data gathering – exploration of falsehood and convictions.

Phase 2. Coram Deo – engaging the word of God in scriptural truths (pastoral conversation, spiritual resources – Holy Spirit, and prayer). Coming before a personal God.

Phase 3. Obedience and perseverance – Addictive cycle (grace cycle and creation of hope).

Phase 4. Support and Follow-up – (community, counsellor).

3.4 Analyses of the relevance of interdisciplinary models for pastoral care of people with faith healing within belief systems among A.I.Cs in L.I.C and M.C.A.N

Table 3-3: Analyses of interdisciplinary model: Relevance to faith healing within belief systems in A.I.Cs in Africa

	ANALYSES	RELEVANCE
A) Psychosocial Models REBT Model	• Clients supported through this model get worse instead of better due to the inefficiency of this approach Efficacy of therapy requires extensive study; • Training, and practice add full grounding in the model's foundations by therapists • Abuse of therapist's power on imposing ideas of what constitutes rational thinking • Clients may feel pressured to adopt goals and values the therapist sells, rather than acting within the framework of their value system (therapists impose their own philosophies of life) REBT, being a confrontational and forceful model, may not be welcome/received well by clients – if clients are weak, they may reject (especially the founder's style) • Atheistic views in REBT, especially criticism of dogmatic religions (philosophies that promote rigid	CARE-SEEKING BEHAVIOUR In western countries, clients have the tendency of seeking professional help if they face challenges or need to make important decisions in life. In some cultures, particularly in developing countries, clients hardly seek professional counseling; some tend to use alternative care options. Clients receive assistance from local therapists known to them, and hardly go to professional counsellors in offices away from their communities. Also, local specialists come to attend to the needs of people – occasionally within their homes – or their families take clients to those specialists within the communities. COST: All western models have cost implications and may not be affordable to all people, particularly those from low-income settings. If a client is not healed in one session, going back requires money and one may opt out of therapy due to financial constraints.

	ANALYSES	RELEVANCE
	belief) may raise problems for religious practitioners or clients who value a spiritual dimension of therapy • Power of positivistic thinking is too superficial and simplistic • Denying client's past and working to eliminate symptoms and failing to explore underlying causes, or ignoring unconscious, underlying conflicts and role of feelings may not bring about holistic healing • Clients can hide in REBT not from seeking to address their problems but hiding in it since it does not address their feelings that may be linked to the root cause of their problems	TIME: since the western models are structured within the therapeutic timeframe of 45-50 minutes to at most one hour, this may restrict clients who may want to receive services from a counsellor/therapist anytime one faces a challenge in life. Dictates of needs for counseling may be barriers to western-timed and expensive models.
Skilled Helper Model	a) Structured and solution-focused basis for counsellors, psychotherapists, and hypnotherapists b) Helps people manage their problems and live more effectively c) Helps develop unused potentialities/opportunities more fully c) Helps people become better at helping themselves in their everyday lives d) Achieves lasting change in the client/counselee	CARE-SEEKING BEHAVIOUR – same as above
PCT Model	• Focus on client alone in communitarian societies is a challenge in care • Process of following through steps – structured for communities that seek and receive counsel anytime, anywhere is limiting • Time allocation for therapy; 45 minutes to 1 hour may leave out those who seek help beyond the set limit. For instance, Africans whose time is marked by events (focus on healing is much more important than time spent) may be challenged. • SOLER – use of this in cultures with boundaries and different frame of	CARE SEEKING BEHAVIOUR Same as above

	ANALYSES	RELEVANCE
	reference may prove unhelpful – eye contact may seem disrespectful, body language and other non-verbal communication may be misinterpreted, distance between genders may become barriers in therapy	
Medical models (BMM, BPS, BPSS)	▪ Medical models provide good guidelines, tools and techniques for care in therapeutic encounters. ▪ Help understand, access and assess human experiences (pain, anger, ▪ grief, solitude). ▪ Gives insights into understanding personal growth.	Segmentation and focus. BMM model is reductionist as it ignores psychological and social factors contributing to ill health; Focuses on pathology and on things that are wrong with clients; Ignores client strength that is vital in overcoming or managing challenge.
African Traditional models	➢ Sensitivity to the African context, use of available resources for care and support, exploiting connectedness as key ingredient for care and wellness, ➢ Provides for caregivers to visit clients or vice-versa, ➢ Uses non-segmented approach to care (holistic)	Non-universality in approach. Non-universal aspects exist – only specific and applicable to people of a specific community, speaking same language, and this stands in the way of inclusion of other people from other communities needing care
Four-Stage model	Hope and positive attitude to problem issues: • Spiritual dimension of transcendence • self-insight and understanding • uses caregiving skills • applies to a number of contexts	Relevant for pastoral care and pastoral counseling. Framework for model/guides to pastoral care and pastoral counseling
Biblical Pastoral Model	• Godly Relationships; • convictions from past experiences; • applicable to diverse situations; • explores falsehood and convictions of care-seeker; • Foundational – Godly relationships, fall of man and attempts to cure pain; and • Engages in the word of God	

3.5 Relevance of psychological models to pastoral care and counseling

Pastoral care and pastoral counseling include interdisciplinary[65] aspects in which the use of both theology and psychology present in ways through which they mediate care in important and new waves within church settings.

Psychological models are integral to pastoral care and counseling because they provide tools needed to understand and interpret the therapeutic conversations. Similarly, psychology makes possible psychological and pastoral assessment and diagnosis and intervention among care-seekers through communication skills and theories. The language and communication of knowledge and skills of care are provided by psychological models.

Similarly, understanding the self and the other in therapeutic conversation is made possible through self-awareness, where one 'understands personal issues and emotional reactions. Caregivers' own responses and feelings are primary instruments for deepening discernment and better care',[69]for lack of it leads to transference and counter-transference in care.

Specific counseling concerns may require the application of psychological, theological and spiritual resources in therapy. The link can also exist between the philosophical basis of counseling techniques in therapy and the counsellor's personal theology. Since human beings are creatures who are somewhat subject to the requirements of biopsychological development as well as to the conditioning of environment, pastoral counseling needs the assistance of psychological disciplines to aid in retrospective[70] analysis of the determinants of human behaviour (Browning, 1985:11).

Use of psychological analysis can greatly increase the accuracy of the efforts of pastoral counseling to mediate transformative resources of the Christian faith. Pastoral counseling presupposes that in the end, it is God's activity working through the process of creation and redemption that brings about growth and change in the helping relationship. It has been noted that the transformative qualities[71] have potency and lasting effect if mediated by real psychodynamic accuracy by increasing self-cohesion, initiative in the care-seeker through sensitivity and

[69] Browning, 1985:12
[70] Browning, 1985:1
[71] This entails looking back toward the causal factors conditioning behaviour. Psychologies help gain backward or historical perspective of a person's life history, by answering questions on what some of the factors that shaped the life of a person (Browning, 1985:11-12) This has to do with the pastoral counsellor's empathy, acceptance, reflections, constancy, and interpretations.

addressing the actual developmental blocks, conflicts, and ambivalences undercutting a person's capacities (Browning, 1985:11-12).

3.6 The models to be used in this study

This study will follow the aspects of the Biblical Pastoral model and the Four-Stage model and African Counseling model mentioned in sections 3.2.6, 3.2.7 and 3.2.8 to develop a relevant model for L.I.C and M.C.A.N. The Biblical Pastoral model (Breed), and the Four-Stage model (Louw) will be integrated (3.5), along with some aspects of the African Counseling model (3.6) to formulate the Biblical model for pastoral care and counseling to show pastors and congregations how to care for people involved with faith healing within belief systems of M.C.A.N and L.I.C.

3.7 Integration of Breed and Louw's models

In this section we hold a discussion on the critical aspects in the models of Breed and Louw – critical, particularly in their phases/stages that correspond, while others enhance each other as they relate to pastoral care.

There are many common elements in the models indicated above in sections 3.4.1 and 3.4.2; hence they can be integrated. In these models, the place of God and dependence on God/spirituality, relationships (both human and human-divine), responsibility, resilience, support, community, warmth, love, true convictions, and correct information are interconnected in caregiving.

Phase 1 of Breed's model, which concerns relationship building and data gathering, corresponds with stage 1 of Louw's model which concerns building trusting relationships and sharing. The connection between the caregiver and the care-seeker creates warmth and sense of acceptance and value of humanity in which the divine human relationship can be formed and nurtured. Apart from the human-human relationships in pastoral care and counseling, Breed's model enhances Louw's model with the correct (desired) relationships between humanity and God, and human dependence on God.

Phase 2 of Breed's model concerns the pastoral conversation about scriptural truths (true convictions), which finds connection with stage 2 of Louw's model that deals with facts and relaying important information related to the situation in a therapeutic conversation. Breed's phase 2 enhances stage 2 of Louw, with true convictions from scriptural truth, which adds to the correct information concerning the situation of the care-seeker.

Phase 3 of Breed's model is concerned with obedience and perseverance in the addictive cycle that deals with the grace cycle and creation of hope has perseverance and hope, likened to the resilience and hope in Louw's Model stage 4.

Stage 3 of Louw's model covers the active involvement of the care-seeker, personal responsibility which are important in decision making and exploration of options in pastoral care and counseling. This enhances Breed's model where it is pointed out that, for one to change and have true convictions, responsibility and decision making are needed.

Phase 4 in Breed's model is about support and follow-up in which the community and counsellors are involved. This phase is particularly important to this study due to the pivotal role of support and community role in care. This study also sees connections of Breed and Louw's models with the African traditional counseling model. This is important, since scholars have shown the need for pastoral care models not only to be culturally sensitive, but also relevant to the needs of the context.

3.8 Linkage of the integrated views of Breed and Louw's models to the African traditional counseling model

From the integration of Breed and Louw's models, we saw that data gathering, relationship and trust building are interlinked. Similarly, scriptural truths in pastoral conversation, facts and information-sharing are interlinked. Furthermore, the care-seeker's active involvement in taking responsibility and making decisions and changing from false to true convictions is instrumental in care. Similarly, follow-up, support, community, and the counsellor's role are all important in care. In 3.4.3 it was pointed out that, in the African traditional counseling model, relationships, community and connections among human beings, and between human beings and God or the supernatural are important. The approach uses culturally sensitive insights, wisdom, and value as it explores connections, but could link with accurate information and true convictions. Relationships count for support in African communities as well as the mystical, spiritual, and physical aspects in care. The interconnectedness in the African model resonates with the human-human and human-divine relationships in Breed and Louw's models as expounded above. For purposes of this study, aspects of these three models will be integrated to develop a model that will be used to care for and support people involved with faith healing within the belief systems of L.I.C and M.C.A.N in Kenya.

3.9 Chapter Summary

In this chapter we presented descriptions and analyses of various counseling models that are used in assisting people with needs so as to gain insight into their struggles and to be able to find solutions to their problems. Both pastoral counseling and psychotherapeutic models discussed serve important aspects in the helping process during counseling of people facing challenges related to faith healing within belief systems. For holistic healing to be fully achieved, a need exists for provision of tools of engagement in therapy where clients could gain insight into and awareness of their context and struggles. Simultaneously, clients ought to be guided and supported to be able to make decisions that can enhance their full functioning in all manners of life – psychological, social, physical, and spiritual wellbeing. Similarly, sensitivity to client context may inform the appropriate choice of a model that facilitates growth and healing in wholeness.

This study appreciates uniqueness and diverse contributions of the select pastoral counseling models which will provide frameworks for developing an integrated model that will provide guidelines to pastors and congregations to care for people involved with faith healing within belief systems in L.I.C and M.C.A.N. From the models analysed above, the Biblical Pastoral model and the Four-Stage model in conjunction with the African Counseling model will be used to develop an integrated pastoral care and pastoral counseling model to assist pastors and congregations in giving care to people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

CHAPTER 4: BIBLICAL PRINCIPLES AND PERSPECTIVES FOR PASTORAL CARE AND HEALING – THE NORMATIVE TASK

4.1 Introduction

This chapter addresses the Normative Task in accordance with Osmer's model (2008:4, 129-173). The Normative task explores the question: 'What ought to be going on?'. This addresses the question: 'What should be happening in this situation?' The normative task employs sound theological concepts that interpret episodes, situations, and context. Concepts to be explored in this chapter relate to faith, illness, health, wellness, and healing in pre-Biblical times; Biblical times (Old Testament and New Testament period as documented in Rabbinic writings, prophetic literature, in the Old Testament; New Testament approach), patristic times and views on illness and healing with specific reference to the healing ministry of Jesus, healing in the early church and in the apostolic tradition (epistles).

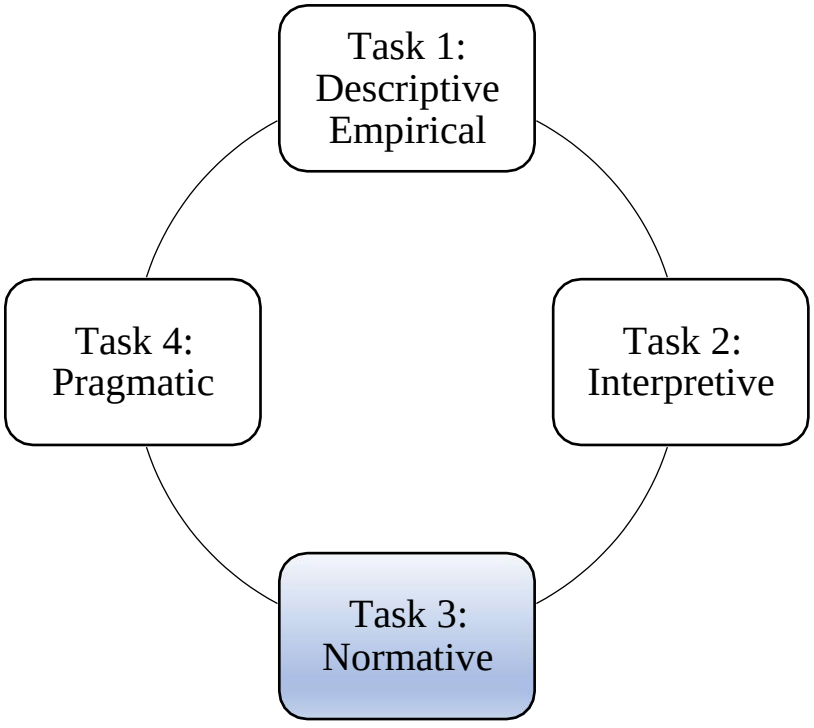


Figure 4-1: The *normative task* asks, 'What ought to be going on?

(Osmer, 2008:11)

The normative task used theological concepts to trace the ethical norms for guiding responses. Doing theological reflections is important since it allows some engagement to establish ethical

norms and values that not only inform, but also allow us to understand belief systems and review the sound responses to faith healing needs within belief systems. It also accords us with ethical norms and space to learn from the good praxis for sound faith healing in the context of beliefs in A.I.Cs. This will further assist in ascertaining the roots of faith healing and their sound practical theological bases in scripture. Theological reflection in this chapter will also assist in determining the place and role of God in health, illness, suffering and healing practices in the scripture and in discussing theological interpretations of underpinnings for holistic wellbeing. This is critical, as it connects and applies the Biblical and theological interpretation to healing practices that are present in the location of this study. This will further enable us to gain a clear understanding for application of faith healing and formation of a framework to be used by pastors who help to care for and counsel people with faith healing tendencies strongly grounded in belief systems in A.I.Cs. This chapter is pivotal as it helps in connecting and applying the Biblical and theological interpretation to healing practices discussed in this study.

4.2 The research question

The research question this chapter answers is: 'What pastoral care and counseling model would help the pastors and congregations with faith healing within beliefs and healing practices in L.I.C and M.C.A.N?' (Pragmatic Task)

4.3 Logical structure of the chapter

Chapter 4 is the normative task that will give the Biblical principles and perspectives for pastoral care and healing. The chapter begins with the overall introduction and then presentsa number of views and perspectives on the concepts of health, faith, disease, illness, and healing as was understood and practiced in context of the pre-Biblical times, OT and NT times, Patristic, Pauline, and time and ministry of Jesus. Special focus on the survey of healing and outlines of pastoral guidelines in the gospel of Mark is given. Finally, an exegesis Mark 5:25-34, and dialogical conversation of the select pericope with other texts in scripture will be done.

4.4 Perspectives on Concepts: Faith, Health, Faith Healing, Belief

Aden (2002:122-123), in Carr *et al.* (2002), sees faith as a response of trust and confidence in someone or something. In Judeo Christian tradition, faith is an empowerment from God that enables a person to believe in and rely on the graciousness of God. Correct belief in a believer's life deals with holding onto God's promises, with God's forgiving love in Christ as the object of faith.

Polkinghorne in SCB (2000.1634) states that faith is the most important element in life, for without faith, it is impossible to please God (Heb. 11:6), although faith has been given by God (cf. Phil.3.12); it is also an act of trust by means of which people commit themselves to someone or something. Faith is believing and believing is the object of people's trust. Faith is also the key to getting one's prayers answered and to seeking for God's will. According to Anderson *et al.* (2000:105) quoted in Marika (2006:4), one is saved by faith (Eph. 2:8) and sanctified by faith (Gal. 3:3-5); people also walk or live by faith (2 Cor. 5:7). Faith is defined as the substance of things hoped for, the evidence of things not seen (King James). Faith means more than belief, as it also implies dependence and trust. As an action, it takes many forms, but does eventuate in changed life. It is living, it moves, and can be perceived, as true faith trusts and depends on God (Fitzpatrick. 2001:133-182).

Parsons (2002.123) explains that faith healing is the popular form of healing which involves religious and spiritual means to effect a cure for a physical or mental condition. Similarly, faith healing for some Christians entails faith in God as the basis for healing. In the NT, Mt. 9.22 presents us with the narrative of a woman who had the flow of blood, and nothing healed her. It is stated that faith (in Jesus) made her whole (well) or saved from the flow that was a social barrier for her (Shelly, 2000:21-22).

4.5 Pre-Biblical experiences of Disease, Illness, Health and Healing

Looking at the pre-Biblical communities helps us understand the views and practices around disease healing and wellness as this also impacted the Biblical communities. Some of the views around disease causation and remedies were common, whereas others were unique to the particular communities before Old Testament and New Testament times.

The pre-Biblical communities in the region of Egypt, Babylon, Mesopotamia and Palestine, suffered from illnesses and diseases. Some parts experienced these diseases and sicknesses due to

topography where some parts were swampy causing rampant water-borne diseases such as cholera, typhoid, amongst others; while other parts were notorious for diseases such as boils, Smallpox and Malaria caused by disease-carrying insects such as mosquitoes. The causes of these diseases were attributed to demonic activity or unseen forces (Harrison, R.K in Bromely, 1982:640).

A number of healing practices existed in Ancient near East. Egypt, in this case, had a physician-established tradition by the 4th Millennium BC, and further had early medical practices dealing with fibre splints, surgery and amputation between ca. 2800 BC and ca. 2500 BC.

Greeks sought healing of supernaturally caused diseases from *iatromanteis*, shaman-like healers. *Iatromanteis* travelled from city to city and purified communities from divine pollution, as in the early sixth century BC did the Cretan Epimenides, who purified Athens; thus, ending a plague that had befallen the city because a magistrate had committed a sacrilege when he killed several men who had taken sanctuary in an Athenian temple (Amundsen & Ferngren, 2005). Disease causation in pre-Biblical times among the Greeks is found in early Greek narratives. The explanation of disease that goes back to an epic poet who was a contemporary of Homer said daemons escaped from pandoras box, moved on their own in the whole world.

Similarly, this narrative regarded disease as retributive, the result of having offended a god or violated a sacred taboo (Amundsen & Ferngren, 2005). By the 8th century B.C, the disease was considered averted when the offense was removed, the affected community purified and Greek pantheons (gods) propitiated. Kaiser (2008) concurs with the above saying that 'throughout ancient Near East, the supernatural forces were considered to be the cause of illness, and treatments were based on a collaboration between seers, doctors and exorcists.

Amundsen and Ferngren (2005) discussed this further by saying that ancient Greece and Rome had four etiological models of disease causation that were not used exclusively, as the ancient societies saw models as complementary. These are the retributive, postulated, magical and natural models. They however noted that treatment prescribed in each model employed specific responses. For instance, the retributive model based on divine causation of illness called for a religious action such as prayer, sacrifice or purification. This differed from the treatment approach linked to demonic causation in the postulated model. In this model, exorcism or divine healing was employed. This also differed from the magical model in which diseases were presumed to be caused by sorcerers or magicians. And for treatment, counter-magic was performed. In the pre-Hellenistic period, the concept of medicine was not well-defined. Usually, a disease was

considered a divine punishment, and for treatment to occur, the priests asked for divine healing from the divinities.

Kaiser noted that throughout the Ancient Near East, supernatural forces were considered the cause of illness, and treatments were based on collaboration between seers, doctors and exorcists. The Greek period brought with it another set of questions, such as whether a patient should consult a doctor or only pray to the Lord. In the early part of the second century, Ben Sira offered an answer which has been normative for religious people up to the present day – to consult the one without neglecting the other (Kaiser, 2001.)

4.6 Overview of Biblical Perspectives on Sickness, Health and Healing

Narratives of people that lived in the OT and NT times communicate a people who not only enjoyed good health, but also suffered from numerous diseases. The Bible has records of both chronic illnesses, for instance in the New Testament records of leprosy, the chronic flow of blood and epilepsy. Unclean spirits, and paralytics (see Mark 3:5; Mt. 12:13; Luke 6:10, Mt. 9:22, Mt. 17:14-20, Mk. 9:17-29, Mark 2:1-2, Mt. 9:1-8 and Luke 5:12-26). Others had short- term diseases that needed healing in order for them to regain their health (shalom), for instance those who had fever and cuts.

Health, according to the Bible, applies to all qualities of life. It encompasses the physical, social, emotional, spiritual, ecological wellbeing and mental wellbeing. Hasel echoes this with the following:

> Healing in the OT is... customarily described as a process which often involves 'medical, surgical, or psychiatric treatment of a pathological condition.' This treatment 'culminates in the functional repair, and sometimes the actual regeneration, of a previously diseased or damaged part of the body or mind.' The OT view of 'healing,' however, is directly related to restoration of that broad state of well-being and peaceful relationship with God, self, fellow-beings, and environment embraced in the OT's holistic concept of 'health.' (Hasel, 1983:197).

From the Biblical texts, the Old Testament healing took various forms and revolved around the eight aspects in the Israelite community. 1. The healing of the body (physical) as well as; 2. Mental and emotional (Ps.147:3); 3. Healing with metaphorical connotations implied is found in (II Chro. 7:14); 4. Communal healing of a whole people; 5. healing of a nation implied in Jer. 6:14, 8:11, Lame. 2:13, Isa. 19:22, Jer. 51:19), 6. Healing of the inanimate as is alluded to in (earth- Ps. 60:2, water- II Ki. 2.21, Eze. 47:8-9, Altar- I Ki. 18:30), 7. Healing of those backsliding or faithless

(Jer.3.22, Hos.14:4), and 8. Spiritual healing as a result of sin as seen in Ps. 41:4, Chro. 7:13-14, Isa. 57:17, Mt. 13:15, Acts 28:27. Hasel, with reference to healing, points this out by saying:

> A person may be described as healthy when he exhibits that state of body and mind in which all the functions are being discharged harmoniously.'' This holistic conception is the essence of the Biblical view of health. Indeed, the idea of wholeness and completeness forms the basic content of the Hebrew word *Shalom,* which can be translated 'wholeness,' 'completeness,' and also 'peace.' He added that, 'the Bible has recorded one of the major manifestations of health shown in longevity.The length of life of antediluvian man as described in Gen 5 surpasses anything known at present, with the total lifespans of the antediluvian patriarchs reaching 777 years at the low end of the spectrum (see Gen 5:31) and 969 years at the upper end (see Gen 5:27). The longevity of the postdiluvian patriarchs was on a distinctly declining scale and reached in most cases only between 230 and 239 years, with Nahor living only 148 years' (see Gen. 1:24-25).(1983:191-192).

Furthermore, resonance with the above is the Mosaic law aspects pointed out by Hasel who noted that the law of Moses took care of ecological health for land rejuvenation. 'every seventh year after the harvest the land is to remain fallow, while orchards and vineyards will remain untended' (Lev. 25:l-7) (1983:194).

Another way of healing in the OT is portrayed in the customary description. Healing is here seen as a process which often involves 'medical, surgical, or psychiatric treatment of a pathological condition.' This treatment 'culminates in the functional repair, and sometimes the actual regeneration, of a previously diseased or damaged part of the body or mind.' The OT view of 'healing,' however, is directly related to restoration of that broad state of well-being and peaceful relationship with God, self, fellow-beings, and environment, embraced in the OT's holistic concept of 'health' (Hasel:1983.197).

4.7 The OT views on Illness, Disease Causation and Healing

The Old Testament Theology of health, sickness and healing depicts God as the genesis of human life that was good; as first creation God created Adam and Eve in perfect conditions, and divine standards (see Gen. 1-2). The opposite of health and good are hard labour, pain, sickness and death believed to be resulting from the fall, when Adam and Eve sinned (Gen. 3). Sickness and death were negations of the 'very good' creation of God (Gen. 1.3.1) Pains from labour such as *working* in the fields (for Adam) or from child-bearing (Eve) confirmed couple disobedience to God.

Similarly, the Old Testament writers were aware that sickness (even to the point of death) could be a disciplinary measure on the part of God toward an erring member of his family. In the Song of Moses, as is recorded in the book of Deuteronomy, God proclaims himself to be the only all-powerful God:

"I put to death and I bring to life, I have wounded and I will heal" (Deut. 32.39).

The 'wounding' that is implied in the above texts is said to may have been part of God's discipline,' but the healing also comes from the same Almighty. From the above OT texts we see evidence that death, life, caring relationship, goodness and healing also emanate from God, as well as evidence of the caring relationship he maintains with his creation (Hill, 2007:153-4). This therefore meant that goodness, care and healing or cures are divine, whereas sickness, disease and ill health were because of human disobedience or sin.

According to the OT evidence then, God can and does heal (Hill, 2007:154). Jer. 30:17 affirms this where God promises to restore the health of Israelites and declares to heal the wounds. The view of the Psalter and prophetic literature on healing alludes to the fact that God in his sovereignty heals much more than the physical. In Psalm 147, David signifies that healing extends to the brokenness of the human heart. Prophets in their literature implied that the environmental health as is seen in 2 Chronicles 7:1 is also from God. Apart from healing of the Land, God also would heal the social, political and spiritual aspects of the life of his people as is written in Hosea 14:4, 11:3, and Jer. 3:22 (Hill. 2007:155).

The Old Testament and Healing discourse had themes in relation to sickness and health, curing and healing in the ancient Israelite community found throughout the Biblical sources. Evidence of God's interaction with his people – Israel showing divine healing – have been recorded from the book of Genesis to Malachi. Israelite belief in divine healing held that God is the one that heals (see also Ps. 33:18-22, 147:10-11). God is the sole source of healing and blessing, God is the source of health and illness, and that Sickness is from the divine. To Israelites, magical or folk healing existed but was considered Idolatry, practised by pagans who were non-Israelites from local cultures.

The divine healing revolved around God's actions in the ill health of his people, with eventual restoration of their health conditions. These miraculous occurrences of healing were clear indications to Israelites that their God (Yahweh) was actively involved in people's lives. Healings that are recorded in the Old Testament revolved around individuals, families as well as community

wellness, and in this case, they concerned all people in the Israelite community. Healing events involved a medium and/or God. For instance, leaders of Israel, and specifically national leaders, prophets, physicians and healers were among those who participated in the healing together with Yahweh, God of Israel.

The OT presents specific accounts of divine healing through the intervention of God who promises to take away sickness and heal his people (Gen. 17:18-19). In the text, Yahweh the healer intervened. For instance, in the case of Sarah's barrenness, God healed her, and she bore Abraham, a son they called Isaac.

In Judaism and their themes of healing, the word for healing referred to the physical and spiritual redemption to wholeness. More so, in ancient Israel, there were themes in relation to sickness and health, curing and healing that can be found throughout the Biblical sources and in later texts and interpretations of the Biblical texts. Israelites located causes for ill health, identified agents behind healing and gave meaning in their interpretations of healing.

Van Zyl in discussing the Old Testament Worldview in relation to healing said:

> In the Old Testament healing is a holistic experience. It is the restoration of all relationships, the restoration of shalōm. To be restored to health is to be saved, not only from pain and potential death, but from all other resulting trials. Above all, it is to experience a normal relationship with *Jahweh* again. To be healed is to be saved in the full sense of the word. Given the *diesseitige* understanding of reality in the Old Testament, to be saved is an earthly experience. It could be primarily physical (medical) or social (juridical) or national (from enemies) or cosmic (from natural disasters). But none of these is ever void of the relationship with *Jahweh*. The Old Testament knows no mere physical, or a mere religious, understanding of salvation (2008:316).

The Old Testament and the Psalms in particular, need to be re-affirmed: In relation to sickness and healing, the Psalms present God as the caring God, as refuge and source of life. The one-sided perspective of God as judging, particularly sexual misconduct, needs to be replaced by the care of God, which is anyway strongly proclaimed in African churches in relation to all other forms of suffering. The holistic understanding of sickness and healing in the Old Testament, that it has to do with all relationships in which one lives, is particularly relevant to the African Worldview.

Throughout the Ancient Near East, supernatural forces were considered the cause of illness, and treatments were based on collaboration between seers, doctors and exorcists (Kaiser, 2001). On the other hand, the health care system reflected in the Old Testament is remarkably different –

replacing the various mystics with a single doctor, often a Levitical singer who also prayed for the sick. The Old Testament reflects a change in the basic conceptualization of illness: rather than an expression of divine wrath, it is seen as the outcome of human sin. Certain theological problems arose from this ideology, including the need to explain the infant and child mortality that was so common during that period. Such questions were partly answered centuries later, by the Hellenistic belief in an after-life. Yet the Greek period brought with it another set of questions, such as whether a patient should consult a doctor or only pray to the Lord. In the early part of the second century, Ben Sira offered an answer which has been normative for religious people up to the present day – to consult the one without neglecting the other. There were certain instances in the Old Testament when people were instructed to use blood, look at a snake in order to be spared or to live as in the case of Moses and the Israelites, and during Passover.

4.7.1 The NT Views on Health, Disease, Sickness and Healing

Healing was an extremely important part of the mission and ministry of Jesus Christ, the early church during the apostolic period, and the later church after the ascension of Jesus. Jesus went to the towns and villages, taught and healed many people with diverse ailments. Although healing of people was not as massive as the healings experienced during the time of Jesus, healing during the times of the 70 disciples and Paul pointed to critical healing aspects of prayer, faith and divine intervention. Narratives specifying each healing event are found not only in gospels but Pauline epistles and Acts of the Apostles. Numerous events of miraculous healings from the time of Jesus to the time of Paul were witnessed and confirmed by faith communities and religious leaders and positively impacted the health seekers' lives. The Apostles got the healing mandate (authority) from Jesus; thus, to cast out unclean spirits or demons, heal every sickness and disease, bring life and preach the good news (Mt. 10:1-7ff).

4.7.2 Healing in Patristic churches

The early church fathers believed in healing that came from God. They stressed various aspects of the healing practices that included prayer, laying on of hands, anointing with blessed oil, and exorcism. Furthermore, Church Fathers considered it normal that believers would ask God not only for the health of their soul, but also for that of their body.

In the healing history of the Patristic period of 100-600, major personalities had exposure to and acceptance of the miracles, and the gift of healing. Healing, which was present in the 1st century church, was experienced through completion of canonization of the New Testament, patristic age,

medieval period, and reformation times (Revival, 2012). Justin Martyr acknowledged exorcism and healing of demons in his second Apology of Ca. 153:

> For numberless demoniacs throughout the whole world and in your city, many of our Christian men exorcising them in the name of Jesus Christ, who was crucified under Pontius Pilate, have healed and do heal. Rendering helpless and driving the possessing, devils out of men, though they could not be cured by all the other exorcists, and those who used incantations and drugs.
>
> Healing during church fathers time was believed to be occasioned by the grace of God, the power of the Holy Spirit, and the response of faith on the part of the faithful and not magic or superstition. Prayer was very important. For instance, for the good of life, health and physical integrity, St. Augustine of Hippo pointed out the need for prayer when he wrote:
>
> We need to pray that these are retained, when we have them, and that they are increased, when we do not have them (Revival, 2012).

For Augustine, prayer sustained the health of people, making them well. There were examples of healing through prayer that St. Augustine acknowledged. For instance, he gives a healing testimony of a friend who obtained restored health through the prayers of a Bishop, a priest, and some deacons in his house. Similarly, St. Augustine emulated the example of apostle James as he visited, prayed, and laid hands on orphans and widows of his time (see James 1: 27, 5, 14). Goar and Denzingerin Graz (1960; 1961) echoed the use of prayers, but also added anointing the sick with oil in the eastern and Coptic churches. In the anointing of the sick in the Byzantine Rite, there is the prayer:

> Holy Father, doctor of souls and bodies, you who sent your only begotten Son Jesus Christ to cure every sickness and to free us from death, heal also your servant from the infirmity of body and spirit that afflicts him, by the grace of your Christ.
>
> In the prayer for healing, the priests asked God through Jesus Christ to heal the sick person, similarly God was invoked in the healing Rite, to bless the oil so that all who will be anointed with it will obtain restored health.

Tertulian (Ca. 170-Ca. 220) in chapter 5 of his work to Scapula gave his account of healing as follows;

> All this might be officially brought under your notice, and by the very advocates, who are themselves also under obligations to us, although in court they give their voice as it suits them. The clerk of one of them who was liable to be thrown upon the ground by an evil spirit, was set free from his affliction; and was also the relative of another, and the little boy of a third. How many men of rank (to say nothing of common people) have been delivered from devils, and healed

> diseases! Even Severus himself, the father of Antonine, was graciously mindful of the Christians; for he sought out the Christian proculus, surnamed Torpacion, the steward of Euhodias, and in gratitude for his having cured him by anointing, he kept him in his palace till the day of his death (Revival Library, 2012).

Healing as deliverance from evil spirits, devils, diseases and demons afflicting people through exorcism and anointing of oil was noted by Tertulian.

Origen (Ca.185-Ca.254) in his writings recognized Paul's scriptural listing of the Charisma, as he spoke of those who obtained the excellent gifts of the spirit. He spoke of the Holy Spirit (See also McDonnell, K. 1994 on discussion on Holy Spirit) as one in whom every kind of gift is contained. In Against Celsius, Origen said that signs and wonders still remain among those who live by the gospel, and also Christians were expelling demons (Baxter,1979:59-60).

Gregory Thaumaturgus Ca. 213-Ca. 270 was acknowledged and respected as was noted by Basil as the wonder worker with the Holy Spirit, who had an active signs and wonder ministry. Gregory also spoke of the great work and power of Basil and the healing of Eusabius and Gorgonia (Baxter: 1979:59-63).

Dionisio, (1991:41-45) gives positions of select church fathers on healing. Aspects of visitations, anointing with oil, laying on of hands, and prayer often feature in the church fathers' ideas on healing of the faithful in the patristic churches. St. Cesarius stressed the power of anointing and healing of the sick, pointing out the virtue and the healing power of anointing of the sick done by the church. He cited mothers with sick children who were healed, sick who were able to walk again, and those weak in faith restored. He also witnessed exorcising in the western church with the purpose of liberating the afflicted from temptation, power of the devil, sickness and from sin.

The other function of anointing with oil was to counter magic rites for healing performed by pagan people. This was echoed by Bishop Eloy of Noyon (588-660) with similar concerns for the faithful of the church to shun magicians, soothsayers, witches or charlatans, to use blessed oil to anoint their bodies in the name of Christ in order to recover their health in their body and soul. Anointing with oil was highly recommended and a priest would say prayers to accompany the anointing.

The consecrated oil was said to have the healing power of Christ and the Holy Spirit of God. Etiquius (512-82) added that for the faithful to receive healing, prayers, laying on of hands and anointing with oil was necessary. St. Polycap, St. Athanasius, and St. Augustine stated that deacons and elders charged with the responsibility of care were to visit as an important practice of care and

cure of the sick. During the visitation, caregivers would visit the sick, widows, abandoned, and orphans, to pray with them, lay hands on them, exorcise the pagan magic and superstitions, but at the same time, comfort, bring joy and assure them of the visit of the priest, and unite with the suffering (stand in solidarity with them).

Demons, sin, temptation, spirits, magic and superstitions, and weak faith brought about the health challenges of people during the patristic period. And for restoration of good health and wellness, the priests, bishops and deacons visited the sick and officiated the rites of healing through prayer, laying on of hands, anointing the sick with blessed (holy) oil and exorcisms. The healing that the sick received was from God whom the church fathers believed was the doctor of people's souls and had also sent Jesus Christ who also healed sicknesses.

4.8 Healing during Jesus' Ministry

In the New Testament healing narratives, Jesus is portrayed as the great healer who possessed the charisma of healing in an unparalleled manner. Jesus' healing focused on the pain, sorrow, injustices, abandonment, slavery of the time and sin. His healing ministry was a prophetic accomplishment of what the Old Testament taught about the messianic promises of liberation (Isa. 35:5-6, 61:1-3, Jer. 33:6, Isa. 53:4).

Similarly, in the New Testament, Jesus' response to the pain, sorrow, sin of the people during his time was compassionate and therapeutic. He touched them with compassion and healed them physically. Jesus had a merciful ear, and with the all-inclusive healing ministry, reached out to the outcasts and affirmed them even when they were dis-membered from their communities. He also understood the people's need for mercy and holistic healing.

The health-seeking behaviour of individuals and communities in Jesus' time, indicates that each person with a healing need had a desire for healing and prayer with reference to Jesus' healing ministry. Gospels show us large numbers of the sick approaching Jesus during his public ministry; directly as individuals (Jh. 9:1-12) or groups, or through friends (Lk. 5:17-39) and relatives, seeking the restoration of their health. Those in need of healing during Jesus' time ranged from common diseases, terminal ailments, disability, psychological challenges, skin conditions, spiritual challenges, and the dead or those possessed by evil spirits.

In all of the healing requests made by the sick and their families or friends, Jesus responded compassionately by welcoming their requests. Jesus did not reproach the sick for these requests

but affirmed them and met their healing needs. His concern was the lack of faith or presence of little faith as we see in Mk. 9:23, cf. Mk. 6:5, Jn. 4:48). Diseases or sickness were attributed to demons, evil spirits, or the will of God. Healing was effected through touch, use of a sick person's faith or the faith of others around the sick, use of natural material (mud) and water, word of mouth and invoking God through prayer.

The Gospels present us with three principle Greek terms used for the healing work of Jesus in the Gospels. First is *iasthai*, which refers to the kind of healing done by a physician (*iatros)* that appears 17 times in the gospel of Luke. The second *sozo*, which means to save, rescue or maintain integrity, always refers to the whole person, and not individual members of the body. *Sozo* appears 16 times referring to healing, and more times (i.e 35 times for other ways of saving a person). Finally, *therapeuo*, a common term used in the gospels in reference to real healing is used thirty-three times in the gospels. Furthermore, Wilkinson (1998:77-78) added that the concepts and words pertaining to healing in the New Testament derive from an Old Testament heritage. Klauck added that the Graeco-Roman world also gave meaning to the concepts of healing (1995, 1996, 2000:289-302). The word most frequently used for healing in the gospels is *therapeuo*, which also has the connotations of 'service' and 'worship' (Acts 17:25) (Wilkinson, 1998:78). A therapon was someone who voluntarily served or attended to another in order to promote their well-being. In the gospels the verb *iaomai* indicates physical healing. This verb is used as a synonym for *sozo* and *diasozo.* This assistance also provides safety from physical dangers or danger caused by divine or human intervention. From a medical-anthropological perspective health in the world of the Bible is understood as a condition of wellbeing (Pilch, 1992:26-33; Davies, 1995). In four cases the gospels give the motivation for Jesus healing the sick as his feeling of compassion or pity (Mk. 8:2, Mt. 15:32; Mt. 18:27; Lk. 10:33; Lk. 15:20).

4.9 Disease, Health and Healing during Pauline times

Detailed discussions of Worsley (1982:317) and Guijarro (2000:103) on Health and Illness in Paul's World indicate that the ways of understanding health and illness in the cultures of Paul and 1st century Christians had similarities with non-western ethno-medical systems that dominated in pre-industrial societies in the common traits[72] in medical systems.

[72] symptoms of the illness are explained on the basis of the belief, an interdependence between the natural, the supernatural, the society, and the person. the 'healer' possesses an intimate knowledge of the patient's social roles and shares the cultural values and social norms of the patient; and crucial participation by primary groups and networks of extended family, kin, and neighbours, in health seeking and treatment process.

Gonzalez, in his work on healing in Pauline Epistles, said that Pauline communities recognised plurality of healing gifts. Paul in Thes1:5 mentions miraculous works which included signs, wonders and miracles (2013:566). Although Paul does not speak strongly about healings in his letters to the churches, Pauline epistles and the book of Acts show a range of healing activities performed by Paul and Barnabas (Acts 14:3-4), Paul (Acts 14:8-11; 19:1-12; 28:8-9; 20:9-12; Rom. 5:15-19, 2 Cor. 12:12, 1 Thess. 1:1).

Those with health needs such as the lame, those with fever, the dead, with dysentery, amongst other health needs, received their health back through signs and wonders that involved calling on the name of Jesus, having faith, touching, use of material prayed for and word of mouth.

Avalos suggests that while we have little evidence of the kind of health care that was given in Paul's world at the level of social network, such care likely would have included various forms of divine communication – simple petitions or therapeutic confessions (1999:37-38) as suggested perhaps by Paul's counsel to the Corinthians regarding 'discerning the body' (1 Cor. 11:27–34), or household/natural remedies.

Etkin noted that cross-cultural studies by medical anthropologists indicate that the use of natural remedies was a widespread mode of self-help, regardless of the socio-economic stratum of patients (1996:149–58), and such studies have been fruitfully employed in discussions of the world of the Biblical texts according to Jacob (1993:27–46). Furthermore, it was noted that when these resources (spiritual and natural) were exhausted, the social network may have played some role in helping ill individuals seek care beyond the popular sector, from either the professional or folk sector. The examples of these are what we see in the Gospels and Acts, kinship and fictive-kin groups interacting with Jesus and the Apostles on behalf of their needy/ill (see Mark 1:33; 7:32; 8:22; Matt. 9:1–2; Acts 3:1–4:22).

The natural family and community as family were very central in the care and support of people who were ill during the apostolic period. Kinship ties, fictive kinship, neighbours were very instrumental in general care giving, advice and diagnosis of the ailment (Lampe, 2003:488–523). Household or natural remedies were employed to treat diseases that impacted the apostolic community.

In the book of Acts, the apostle Paul is reported to have performed miracles in Iconium (13:11-12), healed a crippled man (14:8-18), healed a woman with an evil spirit (16:18), performed miracles in Ephesus (19:11.12), raised Eutychus from death in Troas (20:8-12), and healed the sick

(26:8-9). However, during Paul's time causes of some diseases were unknown (1 Cor. 11:30) while some of the diseases were incurable (Gal 4:13–15. Paul's thorn in the flesh had no cure), in 2 Cor 12:7–10). Similarly, in 1Timothy 5:23, Paul was not able to cure the unending stomach problems of young Timothy whom he counselled, mentored and taught about the power given to him in spirit, and the promise of God to heal and preserve health. However, we see that for Timothy's case, Paul opted to diagnose a natural remedy, without rightly compromising the place of God in healing ailments of his servant.

4.10 Mark's guidelines for pastoral care and pastoral counseling in community

4.10.1 Historical critical location of Mark

Mark as a gospel was written both to and on behalf of a circle of discipleship communities. A number of scholars place the production of Mark in or near northern Palestine. A date prior to 70, and during the revolt of 66 is essential to the coherency of plot and economic theology of Mark's narrative. Both the world of Mark and the work of Mark are situated in the second temple Jewish Palestine under Roman occupation (Myers, 1990:xxx1, 41-42).

4.10.2 The choice of Mark

Using the Gospel of Mark, the researcher explored the Biblical principles and values in the Gospel that would inform the formulation of a model for pastoral care and counseling to assist pastors and congregations with faith healing within the beliefs and practices of L.I.C and M.C.A.N.

The story of Mark is about the narrative of Jesus and was written for and about ordinary people. In the Gospel of Mark, daily realities of disease, poverty and disenfranchisement that characterised social existence of first century Palestine were recorded. At the beginning of the gospel, crowds flocked to John the Baptist, as he promised a new order as Jesus enters the scene, crowds were present, continually pursuing and thronging around him, interrupting and prevailing upon Jesus. Jesus responded with compassion; always first directed at importunate masses and their overwhelming needs and demands. Jesus is shown responding to the masses' desperate situation of hunger and hopelessness and nurtures their dreams of liberation. Crowds still presented themselves even at the end of the day (Myers, 1990:39).

The story of Mark presents us with a variety of challenges in Markan communities and beyond, and demonstrates strategies used to care for people. The experiences of people in the

community of Mark revolved around the themes that are of interest to this study. The themes of faith, lack of faith, community responses to healing, and alternative care options people had and people of faith or no faith in Mark's community. Mark is important as it details the miracles and healing of Jesus in communities with resources or lack of it, but especially presenting Jesus and his response to the needs of people, and the impact of care to care-seekers.

4.10.3 Survey and understanding of illness in the Gospel of Mark

Mark in his gospel presents us with several health needs which we could call medical conditions prevalent in his community. He pointed out conditions such as unclean spirits, fever, demon possession, blindness, dreaded skin conditions (leprosy), haemorrhage, death, paralysis, withered hands, deafness, muteness, and many other medical conditions attended to but were not mentioned. The health or medical conditions of health-seekers in the Markan community deprived them of free association (leprosy, issue of blood, paralysis and blindness), relegated them to dreadful living conditions (graveyards – demon possessed) and impeded health-seekers' status of being in community with their own.

4.10.4 Mark's Presentation of Jesus in Faith Healing and Access to God

There are various views on illness, faith healing, and impact on an individual in Mark's community.

Disease was generally associated with demonic possession (Levine & Brettler, 2017:72), and healing in Mark was associated with enactment of the eschatological promises (Isa. 35:5-6), establishment of Jesus' power over Satan's forces and evidence that the kingdom has drawn near.

Healing of physical and spiritual ill health within the community was not only emphasized but was experienced, as shown in the gospel of Mark (1:33-34, 6:5, 13, 9:38) where people thronged[70] [73]around Jesus. Illness was much more concerned with the sociocultural circumstances of the ill individual in the community of Mark than the physical causes. Levine and Brettler (2017:73) suggest that Jesus' healing of people with conditions that separated them from other members of the community was a healing action that only acted as defeat of impure spirits through actions of the Holy Spirit. The removal of impurity was a sign of regeneration of the community at the end of the age; something that was visible in exorcism (Mark 1:40-45).

[73] See Levine and Brettler, 2017:72)

The community healing stories in Mark give us some insight into the true nature of the mission and ministry of Jesus also to the people. Those cut off from the rest of the members of community were re-united; they had physical and spiritual access to Jesus, and most notably, to God's kingdom. Through Mark those with impediments.

- Accessed divine power through which Jesus affirmed his Christ identity (Mark 1:1-11):
- They received compassionate response from Jesus in their suffering
- They received genuine concern, love, affirmation and embrace as isolated individuals in society (2:5, 6)
- Those who were excluded and isolated and minorities were reintegrated with their community upon healing (woman with flow of blood, lepers, demon possessed, mute and dumb, paralyzed: Mk. 1:40-45; 5:19-20)
- They expressed therapeutic participation, determination, and strong sense of faith in Jesus through active stance of health seeking for healing in '…only touch' (Mk. 5:24-34; 7:24-30; 9:23-24)
- For them, social, communal, and psychological healing, community rights, rehabilitation and access was made possible through Jesus

In order to come up with the principles and values that will guide pastoral care and counseling, the researcher did a historical critical and textual exegesis of the selected pericope – Mark 5:25-34.

4.10.5 Exegesis of Gospel of Mark with focus on Mk. 5:25-34

My thesis is that healing of the daughter of the synagogue ruler would not have happened without the outsider interruptions that created a relationship, integration, and connection to the source of healing power. The woman, who was an outsider in the community was also vulnerable, fragile unsupported but had access, through faith in the healing power of Jesus present in the community and insisted on touching his cloak. She risked her life, but assured life for others – healing for the 12-year-old daughter and for her community as well.

Mark chapter 5 is encapsulated in the Jewish-class relationships and socio-economic realms in the Jewish territory. Just prior to the narrative of the lonely, weak, and vulnerable female patient, Jesus is approached by a Jewish ruling class member of the synagogue to heal her daughter.

The flip side is that the multitudes by the sea following Jesus, indicate the socio-economic status of a people-poor people (Myers, 1990:200). The issue of class is certain, and the fact that Jesus was interrupted on his way to healing a daughter to a ruling class member, the one accorded honour, and she came alongside the crowd signifies her social location.'

Myers (1990:201) states that the female patient was poverty-stricken among other poor people in the crowd, in 'shame' category, the female patient is with no name, no status, and is an outcast. She reaches out from the crowd that was pressing in on Jesus from all sides, defenceless, ashamed, with covert attempt to gain healing. Additionally, because of her physical condition of unarrestable haemorrhaging she should, according to the Levitical purity code, have been perpetually segregated, and again remained a victim of exploitation.

> Shame in this context refers to a person's sensitivity about what others think, say, and do with regard to his or her honor…natural groupings have collective honor and shame.
>
> But in the moral division of labour…honor and shame became sexually specific, sexually embedded. The male is to defend both corporate honor and any female honor embedded in the corporate honor, that positive sensitivity to the good repute of individuals and groups (The New Testament world, insights from Cultural anthropology,1981:47f).

Biblical guidelines for pastoral care and pastoral counseling guidelines in the context of suffering will be drawn from the gospel according to Mark chapter 5:25-34. Care of people who need healing in community is a theme present in both the NT and OT. In the canonical gospels, Mark in healing ministry of Jesus, portrays Jesus as the healer, encourager, comforter, consoler, interpreter, diagnostician, a voice for the voiceless and hope.

V. 25 an issue of the blood

Pfeiffer and Harrison (1990:998) say issue of the blood as used by gospels denote a chronic ailment as no one gospel specifically describes the nature of ailment of the female patient in the crowd. Coogan (2001:66) saw the woman in V.25 as poverty stricken, from a worsening haemorrhaging disease that no physician could stop and based on the purity code (Lev. 15.25-30), she would also have been unclean. Brown, Fitzmyer and Carm (1968:33) stated that the uterine issue of blood

V.25 *issue of blood* made the woman ceremonially defiled according to Leviticus 15:19, 2; hence her deepest need for healing. Henry (1968:1375) said vs. 25-27 present us with a case of a poor woman who had had a constant issue of blood for 12 years. She had the best physicians she could get, had used many medicines and methods, had spent all her money on them, but the healers gave up on her, rendering her *incurable* as she had tried all they offered but got no healing. Falwell (1978:106) added that the woman with the haemorrhage not only had the condition for 12 years, time and again, but endured painful treatments by many physicians, but sadly the bleeding grew worse, and doctors were unsuccessful in healing her.

Mark in the healing narrative here refers to the woman with continuous flow of blood, which causes ritual impurity with a different response commanded, as found in the Old Testament book (Lev. 15:19-30). Therefore, since she was impure, she was not welcome to mix freely with community members as she would also make others who come in contact with her impurity. In Mk. 5:25-34 it is often assumed that this miracle depicts Jesus' rejection of Jewish purity codes, seen as onerous for women. The likely contrast may be between sickness and healing based on faith, as is stated twice in the text (v. 28-29, 34). v.25 suggests a reference to the renewal of Israel as a whole, where 12 can stand for the 12 tribes of Israel (Levine & Brettler, 2017:80-81).

Coogan, Brettler, Newsom and Pheme (2001:66) note that v. 27-33 recognize that the initiative and action to seek health are entirely those of the woman, and Jesus though passive, is a conduit through whom the healing power goes forth to heal the woman. Brown, Fitzmyer and Carm (1968:33) said that the woman's demeanour in *V.28 I will be healed*, as that of Jairus' daughter is presented as a paradigm of access to Jesus Christ. Jesus is described as possessing an almost magical healing power that heals automatically upon contact with him. Falwell (1978:106) stated that the long 12 years of suffering and worry ended in a single act. Straight away, she washealed, and she knew it. Henry (1960:1375) said v.28-29 '*if I may but touch his clothes, I shall be whole'* the woman had strong faith in the power of Christ to heal her. And due to her belief action of daring to touch, a wonderful effect was produced. She came in the crowd behind his, she got to touch his garment and immediately she felt the cure come upon her. The flow of blood dried up and she felt herself perfectly well all over her in an instant and things changed for the better after accessing Jesus.

Falwell (1978:106-107) notes that in v. 30 the power of Jesus was released with his knowledge and his will because he permitted healing upon the woman to deliver her from her incurable disease. Brown, Fitzmyer and Carm (1968:33) say that v.30 shows that 'faith' of the health seeker

is a necessary disposition in order for the miracle to effect the deeper saving reality it symbolizes. On the other hand, Henry (1960:1375) points out that the inquiry (*who touched me*?) was based on Jesus' awareness of who had touched him, and was meant to affirm the woman, and encourage her. Jesus asked with a desire to see her, with tenderness and genuine concern for the woman. The question posed by Jesus was a response to the issue of power leaving him through the touch, mentioned by Cadenhead (2008:18). In v.31, *fear and trembling*, Falwell (1978:107) sees the inquiry as Jesus allowing the woman to give a testimony (confess) what had happened to her restored body. Brown, Fitzmyer and Carm (1968:33) see v.31 as a response of the woman, because of the sweet surprise, when Jesus asked who had touched him, and this represented some of Christian sentiments seen in Pauline epistles (1 Cor. 2:3; 2 Cor. 7:15; Eph. 6:5; Phil. 2:12).

Henry (1960:1375) sees this as commendation and encouraging on the part of Jesus to reveal the courage of the woman only seen by the Lord, that caused individual and private healing to be publicly confirmed through telling the truth about what the Lord had done. Fawell (1978:107) notes that, in v.33-34, direct communication with God is emphasized. Further experiencing the power of Jesus was important, but what was more critical was knowing him (God through Jesus as the source of the power) – one through whom the woman's body was restored, and the Lord spoke peace confirmation of wholeness. Brown, Fitzmyer and Carm (1968:33) see that '*Your faith has brought you salvation'* in v. 34 refers to the unnamed woman being saved, through faith, from the disease, scourge, whip of blood, which was regarded as punishment.

With reference to Mk. 5:25-34, Cadenhead (2008:35) suggests that Mark's gospel usually gave the recipients a voice, asking Jesus to heal them, and allowing them to tell Jesus that they believed in his power to heal. This allows Mark to stress multiple times Jesus' power to heal physical ailments as long as the recipient has faith, as in the story with the haemorrhaging woman when Jesus tells her: 'daughter, your faith has made you well' (v.34). Faith here is given significancein healing of the female patient in the crowd. Pfeiffer and Harrison (1990:998) regard this as faith in action, with a confidence so strong that the female patient did not need to see the necessity to draw the attention of Jesus (v.27, 28).

Henry (1960:1375) saw the verse referring to the grace of God which is a seal of faith, and it was so that through faith by the grace of God, the woman with the issue of blood was made whole and she went in peace.

From the discussion above we can deduce the following key Biblical principles and values that are useful in a model that would be used for pastoral care and counseling of people involved with faith healing tendencies within a belief system:

- Knowledge of God and Jesus Christ with the power to save one in need of deliverance;
- Grace of God that seals health seekers' faith and belief in God and Jesus;
- Faith and belief in the healing and saving power of God;
- Direct access to and communication with Jesus/God by the health-seeker;
- Action/initiative of the health-seeker to intentionally act in faith;
- Need for healing, and identifying source of an ultimate solution;
- Encouragement, caring support, confirmation and affirmation, from the caregiver;
- Health-seeker's testimony – truth, acknowledgment;
- Awareness of healing and knowing the healer (Christ the deliverer);
- Sharing with others to see restoration, wholeness and peace; and
- Cleansing, making pure for reintegration into community and kingdom.

4.10.6 Mark 5:25-34 in conversation with other texts in Scripture

Churches, during Paul's time, also indicate that sick people of the time were instructed to call upon elders of the church to mediate the process. Healing was occasioned by the elders laying hands on the sick person, anointing with oil for being set apart and invitation of God's spirit for special miracle of divine healing of the sick person's body (James 5:15 *The prayer of faith will save the sick, and the Lord will raise them up; and anyone who has committed sins will be forgiven)*. Prayer for the sick in the early church was accompanied by faith, and the sick person was made well. The apostolic church further experienced miraculous healing through contact with the apostle Paul. Other people also prayed over materials that brought healing, for instance handkerchiefs or aprons that had been prayed for, were placed on individuals for healing (Acts 19:11, 12). Faith was also key to please, draw near to and believe in God (*And without faith, it is impossible to please him,*

for whoever would draw near to God must believe that he exists and that he rewards those who seek him – Hebrews 11:6).

We also see that during the time of Jesus in the gospel of Luke, Jesus acknowledged the faith of friends of the paralytic; thus, Jesus healed and forgave the sins of the paralytic. When he saw their faith, he said, '*friend, your sins are forgiven you'* (Lk. 5.20). The blind man was also healed by Jesus based on his faith (*Jesus said to him, 'Go; your faith has made you well.' Immediately he regained his sight and followed him on the way.* (Mk.10:52).

OT highlights God's sovereignty and his ability to heal. No sickness, not even death, is beyond his capability to overcome. God called himself *'the LORD who heals you'* (Ex. 15:26). Moses took Yahweh at his word and called upon him to heal his sister Miriam of her leprosy, which God did (Num. 12:13f). David the psalmist described God as the one who *'heals all your diseases'* (Ps. 103:3). The prophet Elisha prayed to the Lord, and the Shunamite's son was raised from the dead (2 Kings 4:32-35).

From the OT, God was believed to be the healer of all diseases and giver of life. In the New Testament passages, we have selected faith was key in the healing and miraculous experience during both Jesus' ministry and Pauline churches and the larger early church. The faith of the care-seeker or the friends and family caused the sick to be healed, forgiven and saved. We see that in all these texts including the pericope for exegetical work in this chapter, the recognition of God, the place of God and trust in him and his son Jesus Christ resulted in healings of the woman in Mark, the blind and all care-seekers not mentioned here but were in the ministry of Jesus, in Pauline churches and the early church.

In the OT and NT healing experiences, friends, leaders and church community also played a key role not only in support of care-seekers, but also in actual healing exercises. We see Jesus, Paul, elders, woman patient, friends, parents, Elisha, David and Moses all participating in the healing experiences of those who needed healing care. We also see in some healing incidents active participation of care-seekers themselves through faith and presence.

4.11 Conclusion

The aim of this chapter was to explore Biblical principles and guidelines that could be used to inform strategies for pastoral care and pastoral counseling to be used by pastors and congregations to support people involved with faith healing within the belief systems of L.I.C and M.C.A.N.

Historical critical exegesis of Mk. 5:25-34 was done on the pericope about a woman who suffered for 12 years, went to many doctors but was not healed until she trusted and reached out to touch the hem of the garment of Jesus. The active role of the woman, her faith and trust in Jesus made her to risk breaking cultural barriers to receive healing. Jesus' willingness and invitation made her feel recognised, given a new identity, 'daughter', a title of one who is a member of a family. The principles of:

- Knowledge of God and Jesus Christ with the power to save one in need of deliverance;
- Grace of God that seals health seekers' faith and belief in God and Jesus;
- Faith in and belief in the healing and saving power of God;
- Direct access to and communication with Jesus/God by the health-seeker;
- Action/initiative of the health-seeker to intentionally act in faith;
- Need for healing, and identifying the source of an ultimate solution;
- Encouragement, caring support, confirmation, affirmation, from caregiver;
- Health-seeker's testimony – truth, acknowledgment;
- Awareness of healing and knowing the healer (Christ the deliverer);
- Sharing with others to see restoration, wholeness, peace; and
- Cleansing, making pure (complete healing) for reintegration into the community.

In putting the pericope in the gospel of Mk. 5:25-3 in conversation with select text in the Old Testament, the New Testament particularly during Jesus' ministry, Pauline and early church, the study established that the deity, the second person of the Trinity, faith, care-seekers, family, acknowledgement of faith, healing, restoration, community and trust were common.

CHAPTER 5: A BIBLICAL PASTORAL CARE AND COUNSELING MODEL FOUNDED ON BIBLICAL PRINCIPLES – A PRAGMATIC TASK

5.1 Introduction

This chapter focuses on the fourth task in practical theological interpretation – The pragmatic task. The pragmatic task will answer the question, 'How might we respond?' The task is shown in the diagram below (Osmer, 2008:4; 2011:2).

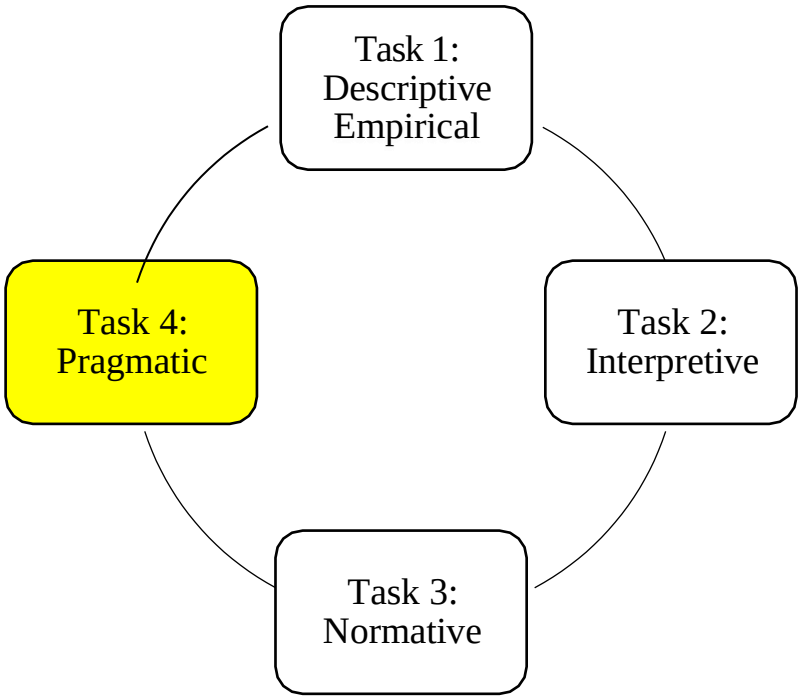


Figure 5-1: The Pragmatic task (adapted from Osmer, 2008:4; 2011:2)

This chapter is based on the central theological argument the researcher formulated in chapter 1 which stated that 'an integrated Biblical pastoral care and pastoral counseling model can enhance care for people involved with faith healing within the belief systems of L.I.C and M.C.A.N'.

In order to come up with strategies for the model being proposed, we will discuss the results of the empirical study done to investigate the current healing practices and beliefs of L.I.C and M.C.A.N (Empirical-Descriptive), the literature study on the role of interdisciplinary models of care and counseling (Interpretive), and the historical-critical exegesis of the Biblical principles and perspectives on pastoral care and counseling in the select pericope Mk. 5:25-34 (Normative).

5.1.1 Objective

The objective of this pragmatic task is to develop an integrated Biblical pastoral care and pastoral counseling model. This model will demonstrate how pastors and congregations may be assisted in helping people involved with faith healing within belief systems and healing practices of L.I.C and M.C.A.N.

The aim is to formulate and discuss principles, perspectives and guidelines that might be foundational in the model to be proposed that will be used by pastors and congregational leaders in pastoral care and counseling to people involved with faith healing within belief systems. Results of the descriptive-empirical research, interpretive research, and normative research in chapters 2, 3 and 4 will be used in the discussion and fusion to achieve the objective of the pragmatic task in the sections that follow.

5.1.2 Logical structure of the chapter

Chapter 5 is the pragmatic task that begins with the introduction to the chapter, objectives, and main research findings of the study. The findings give a detailed report about pastoral care, pastoral counseling, and healing practices found in M.C.A.N and L.I.C churches. Further, the role of interdisciplinary models in care and counseling with focus on the Four-Stage model principles and values of Louw, and Breed's model are given. A conversation between the two models with the exegetical work done on Mk. 5:25-34. Key principles, values and perspectives from the two models and those of the select pericope that make core to the proposed Biblical Pastoral care and counseling are discussed. Similarly, an amalgamation of the empirical research findings with the literature view, interdisciplinary models, and exegesis of Mk. 5:25-34 is done. Finally, the chapter gives a proposed integrated alternative Pastoral care and counseling model to help congregations and pastors in L.I.C and M.C.A.N that is formulated based on literature reviewed, the thematic areas and principles from empirical study, interdisciplinary models, and the exegetical work done on Mk. 5:25-34, before giving a conclusion to the chapter.

5.1.3 Dialogical presentation of research findings, literature review and exegesis of Mark 5:25-34

This presentation will include findings of the literature review done on sources that covered areas of faith healing, care, belief systems, illness, health, pastoral care and counseling, OT and NT, experiences of L.I.C and M.C.A.N in the empirical research and the exegetical work done on the

selected pericope Mk. 5:25-34.

5.2 Current situation of care and healing practices among L.I.C and M.C.A.N – Descriptive-Empirical task

Findings on the current situation of care is divided into participant demographic information (5.2.1) and the healing practices and values from 5.2.2. The research was done among 50 participants who were members as well as leaders from the L.I.C and M.C.AN churches involved in caregiving. 35 were men and 15 women. Participants' ages ranged between 29 and 82 years.

5.2.1 Caregiving practices and resources

The results of the MMR inquiry in chapter 2 demonstrated that all participants members and leaders alike, of L.I.C and M.C.A.N were aware of the caregiving strategies and resources available in their congregations.

One of the participants said:

> When I feel sick and go to church for healing, Nabii talks to me. Then I go to the place where the healing mat is. I lie flat facing down and Nabii prays for me as he puts his leg on my part that is paining…uh, like on my back, leg, head or anywhere.

Another participant said:

> The high priest tells me to take animal for sacrifice, uh…. I am asked to touch the head of the lamb and high priest prays for me. Then after sacrificing, he places the parts of the meat on the altar and prays to Jehovah *Wanyonyi* to accept my sacrifice and heal me and makes burnt offering.

Another participant said:

> In my church I take oil, and incense, and money, and flour gifts to *Mama Kanisa* for my sin offering and gift offering and appreciation.

Another participant said:

> I take an animal like young bull or goat or also chicken or money to Nabii for sacrifice or appreciation.'

Caregiving practices and resources in the churches include prayer, visitations, ritual care, holy touch, anointing and presentation of gifts. Care providers are all church leaders who are men and women in L.I.C and M.C.A.N, and social workers, school personnel, community traditional healers and hospital caregivers. Caregiving in the two churches also includes sessions for both individual

and family advice given by Nabii, Jehovah, high priest, *Mama Kanisa*, healers, and disciples.

Caregivers were aware of religious leaders involved in care that include the afore-mentioned leaders who give advice, plus judges, diviners, angel mediators, and prayer worriers.

5.2.2 The place of God in care-seekers' search of care

Participants pointed out that almighty God for M.C.A.N and Jehovah *Wanyonyi* for L.I.C are deities that are involved in their lives. God in M.C.A.N is the creator also known in Christian churches, and God is seen as both transcendent and immanent. God is present in rituals performed in church or in the lives of members. The relationship is that of 'over-againstness presence of God'[74], with demands through the founder, like Yahweh of the Old Testament (Oates, 1986:87-89). The L.I.C knowledge of God as god Jehovah *Wanyonyi, Mungu aishiye, muumba mbingu na nchi*[75]. Their deity is seen as the incarnate immanent god who is active in real-life experience, and is alongside people, helping them, and advocating for them (Oates, 1986:85-89). Although different, this resonates with what Pastoral caregivers ought to be clear to communicate the very presence of God, in silence, listening and sense of community. God moves in human situations of pastoral care and pastoral counseling (Oates, 1986:81). Freedom increases as God becomes more fully immanent. The reason for acceptance of the gift of freedom means opening up to God or choosing God. God's incarnate presence, trust, presence of God and transformation of care seeker and caregiver makes growth possible through pastoral counseling. Groups or communities in churches ought to work together towards strengthening one another in the discernment of the working or the divine and alignment of their lives (Cobb, 1973:50-52).

5.2.3 Rituals in religious care

L.I.C and M.C.A.N are highly ritualistic churches in their response to needs and in worship. The specific religious rituals include sacrifices on the altar, baptism, circumcision, anointing with oil, holy touch, offerings, oracles, and visiting shrines. Participants attested that rituals in the church help them in their search for healing as they experience love, care, peace, and support.

[74] Oates uses two metaphors of the presence of God -alongside and over againstness. In the 'alongside' metaphor, God's presence is that of a friend, stranger, family, or one with us, who labours with us, in fellowship with us walks with us, guides us, and one who fortifies us with courage. The overagainstness metaphor for the presence of God conveys a deep sense of otherness, with awesome difference from us, disfavoring us or one who makes demands and expectations from us.

[75] The living God and creator of heaven and the earth – in reference to the deity who is both human and divine – Jehovah of L.I.C.

The participants were aware of some impacts that ritual care have on their lives, and of religious resources available for care. They said that caregiving skills of caregivers give them the much-needed ability to support care-seekers. However, the MMR study also revealed that the satisfaction level of care-seekers from L.I.C and M.C.A.N was low. They said that they still face challenges while seeking for care. These included lack of food for their families, lack of children's school fees, stigma, and ridicule, being treated indifferently, being disrespected, being shunned, strained relationships, unemployment, lack of money, long distances to and from church, threat to life, and delayed care due to inability to buy gifts and re-occurrence of challenges

5.2.4 Rituals, sacrifices, blind spots, and pastoral responses

In their challenges, challenged persons seek the service of a diviner outside the church. This makes it possible to attend to personal concerns voluntarily and deliberately and strategically, involving self-awareness in ritual means of a choice. Care-seekers can choose whether or not they wish to engage the diviner. Similarly, there is no coercion in seeking divination. Diviners determine affliction in spiritual disorder with the aim of determining what sacrifice will appease those involved, rectify the situation and alleviate the suffering (Michael, 1989:59-63). During divination, the diviner sees the sacrifice, while the client makes the decision regarding whether or not to perform the sacrifice. The idea that in divination the decision is made by care-seekers and not caregivers (diviners) is not known by many care-seekers.

One participant said:

> There is a lot of witchcraft in my community, and when we get attacks in family, I take my children to diviners to counter strong evil powers of Witchcraft. My children feel safe and strong after the visit.

One of the issues diviners deal with is witchcraft, which involves beliefs and practices of negative forces that are so threatening that they need protection and services of divination, purification, sacrifice and herbal remedies. These beliefs instill fear and anxiety when people suspected of being witches appear or are mentioned. Divination explains these brutal forces that cause mysterious deaths or prolonged illnesses.

When pastoral care givers are working with people who have beliefs of witchcraft and divination, pastoral caregivers at this point should work with care-seekers to make them understand the responsibilities they have and the choices they make in the process of seeking help from diviners. Care-seekers are not inactive in the decision being made. Dangers of syncretism is that it dilutes

the gospel message with regards to either openly or secretly consulting diviners.

5.2.5 Animal Sacrifices verses Christ's atonement

The empirical study showed that both churches use sacrifices as part of healing for people who come for care in the church. Animals or birds are sacrificed and offered on altars in L.I.C or altars and shrines for M.C.A.N.

> As instructed, I bring lamb or bird to church for healing offering. It must be blameless according to the law of Moses. This animal is sacrificed, and blood smeared on altar and selected parts burnt on the altar after prayer and forgiveness, and the smoke goes up.

Sacrifices can be private altar offerings, gifts, initiations, amongst others. Blood sacrifice is the typical one, and through blood sacrifice in most ATR, deities and ancestors are fed; hence the relationship is sustained. It can be demanding, and ritual defaulters can be afflicted by disease. M.C.A.N make blood sacrifices with the care-seeker bringing the prescribed animal or bird and the *Nabii* officiates the offerings at the altar, sanctuary, and the shrine in the church compound or near the river. L.I.C care-seekers bring the prescribed lamb that is offered on the altar by the high priest, while following the law of Moses.

At this juncture, pastoral caregivers can share scriptural truths with care-seekers about lack of need for total reliance on animal sacrifice for Christian faith communities. Clarifications could be made on the place of traditional community rituals, and the meaning of Christian rituals and faith in God and in Jesus, and particularly the place of the person of Christ and eucharist in healing, salvation and remission of sins. Pastoral caregivers are to refer to the elder brother and ancestor, per excellence Jesus Christ, whose blood finished all. Belief in him (Jesus) assures care-seekers of protection and healing in the power that is in the blood of Jesus. Similarly, pastoral caregivers ought to share with care-seekers and point them to the eucharist, Jesus's table, where sharing in table fellowship means sharing in life, the essence of the mission of God in Jesus. This is at the centre of God's mission, and what comes to the fore is space when people meet Jesus; people are touched and embraced by God, are supported, cultivated, empowered, and affirmed. The heart of God is love, to be saved is to be embraced by this love, and to become healthy is to be enveloped in the love of God (Song, 2001:124-126).

5.2.6 Pastoral caregivers' responses to rituals

Care-seekers said that rituals in their churches are very important. One participant said:

> I go to church when I feel bad and Nabii tells me to take goat or chicken. When they are sacrificed, I feel relieved, I do not worry about the attacks of bad spirits.

Another participant said:

> High priest receives my lamb, and he asks me to place my hands on the head. When it is offered on the altar, high priest prays for me, and I feel Jehovah *Wanyonyi* hears me and I go home with peace. I feel better afterwards.

Caregivers in this care can recognize that there are human negative forces, and also human good in communities that are only temporal. Caregivers should acknowledge the presence of human negative forces and threat to life and point people to the ultimate (divine) sources of good and life-giving force in God, Jesus, and spiritual resources to address the fears care-seekers may have. Caregivers should point care-seekers to the mighty God who is omnipresent and creator, God of gods, and use scriptural truths to edify, and use some texts such as Ps. 23 to encourage people who are hopeless, discouraged and need assurance.

Pastoral caregivers can utilize the Christian community space, where rituals of celebration and sacraments take place within the body of the church to build them up. Caregivers can share with care-seekers about sacraments such as baptism, and holy communion and the full extent of meaning of God's saving love for all people and God's purpose to spare/give life to all people including the Christian community as is written in scripture. Through baptism, care-seekers are joined to Christ through death and share in the new life of resurrection and is connected back to God. They no longer have to do animal sacrifice, because Christ's atonement is enough for all people. Furthermore, caregivers can use teachings from scripture to prevail on care-seekers to live as God's children.

5.2.7 Legalistic and authoritarian impacts on care

The study revealed what the participants were not cognisant of authoritarian and legalistic impacts in the care and healing strategies of the L.I.C and M.C.A.N churches. Some aspects are of legalistic and authoritarian nature. This impacts on the overall care as care-seekers tend to experience effects on relationships with caregivers. In the two churches, care-seekers must strictly obey laws, rules, and regulations of individual churches in order to receive care. Participants indicated that care-seekers totally depend on and follow what the leaders or founders and healers of the churches say and accept healing without airing their views. The rules, instructions and commandments are to be fully obeyed.

One participant said:

> I follow the law of Moses to keep pure, and I don't work on sabbath. When I follow the rules, and commandments, I am cared for and blessed by Jehovah *Wanyonyi*.

Another participant said:

> When Nabii has said it is final. I cannot say anything…. uh I just follow so I can receive healing.

This affects relationship between the care-seekers and caregivers since one sees that it is unbalanced, as the model used gives power to leaders and the top-down approach creates room for dictatorship in caregiving. In the process, it instils fear, intimidation, and rebellion[76] at certain times. Eventually, care-seekers in L.I.C and M.C.A.N experience a build-up of strong fear, anger, frustration, bitterness, stress, depression, anxiety, hopelessness, and lack of trust.

Pastoral care providers need to recognize all issues and pay attention to them. They ought to consider doing pastoral care to cover forgiveness pastoral care and pastoral counseling using pastoral skills and functions so that the informal and readily available traditional approach may be effective. In using pastoral skills and functions, caregivers will create a therapeutic environment in which warmth, understanding, empathy, compassion, and communication will be exercised. This will in turn make pastoral care and counseling for reconciliation[77] care and counseling for anger management care and counseling of care-seekers is done before it leads to a build-up of too much pressure[78].

5.2.8 Awareness on formal and professional caregiving

Participants in the two churches (L.I.C and M.C.A.N) said there are no formal professional pastoral

[76] This occurs because of management and manipulation by people helping care-seekers where care-seekers impatiently reject mechanic and dehumanizing help (Combs, Avila & Purkey, 1978:186).

[77] Reconciliation is a large part of pastoral counseling where people who are finding fault with each other need to be supported to make amends. Pastoral caregivers create room for them especially since they hardly see one another face to face, and when the do see each other, emotions are high and do not deal with each other gently. Pastoral counseling will utilize the skill of listening in order that they may understand or hear the other person out (Mt. 18), Gal. 6:1-10 is powerful for realistic reconciliation. Pastoral counsellors could do conflict resolution among people or members who are at odds, and may be give them a moment of silence to experience God as in Rev. 8:1, and the book of Job -silence as the best teacher (Oates, 1986:77-81)

[78] In both L.I.C and M.C.A.N, Care-seekers have to earn healing and yet in Christ, they receive it freely, with gratitude and caregivers serve care-seekers through the love of God.

caregivers in their congregations to meet the social, psychological and spiritual challenges. The study established that the limited social and spiritual support system care-seekers have, is from ordinary members of the church who have never been trained. Caregivers in L.I.C and M.C.A.N who have limited informal education and training are the core caregivers of pastoral care and pastoral counseling services. This is not formal pastoral care and pastoral counseling or professional, as all caregivers are not professionally trained, and are either unschooled or semi-illiterate according to the empirical research findings (the highest level of education was secondary education with the majority of leaders being unschooled).

5.2.9 Pastoral ethics

Participants were also not aware of ethical consideration in pastoral caregiving. The work of pastoral caregivers involves 'intimate relationship'[79] of life, be it long- or short-term and in the intimate therapeutic relationships. People turn to pastoral caregivers for ethical insights as they wrestle with ethical perplexities of human life. The pastor and other caregivers mirror how values of life are to be held as they exemplify in the pastoral leadership, but also in life and praxis. Responsibilities are required that pastors and other caregivers should take upon themselves around disclosure, communication of information that may cause shock or anxiety, such as a terminal condition with no cure. Furthermore there are aspects that govern them in therapeutic relationships, such as rules by which the pastor or caregivers discipline themselves in obedience to the higher authorities, inner sensitive conscience concerning the privileges/responsibilities in ministry as they seek guidance from God, even when they are to make the best individual final judgement, agreements relating to biases of personal preference or indulgence in social approval, interpersonal relationships and ethical responsibility of each person (Johnson, 1953:286). When a pastor or any other faith community caregiver calls on someone/care-seeker in need of care, caregivers represent the Christian community to signify its faithful concern for one who suffers and expresses willingness and readiness to communicate unconditional love and sustaining care of God (Johnson, 1953:197).

5.3 Neighbourhood and community network and attitudes

Communities around the churches are not willing to come closer. Participant J said that residents in the community who belong to other churches run away from believers of L.I.C. Participant N

[79] Johnson, P.E. 1953. Psychology of pastoral care. The pastoral ministry in theory and practice. Abingdon, New York.

said that they are treated with suspicion because they belong to the M.C.A.N church.

When people see you coming out of the church, they talk in low voices and disappear. They only come back to the road after you have gone. Some of the school communities also treat faith-related issues of some students in a biased manner. Participant A said:

> My daughter was sent away from school due to lack of fees. When I went to school to ask for financial support for poor families, the teacher laughed at me and told me to go back and ask Jehovah to provide. The teacher added: How can you have god and be poor?

The participant felt discriminated against, because she was a firm believer in the L.I.C church.

Participant B also said:

> Some of our neighbours do not come to our home or even greet us….when they see me coming, they divert on the road and you hear them saying, 'one of those people is coming'….so we live in a community, but we are on our own island.

The participants said that this happens every time neighbours see them on the road, and they feel segregated and made to feel less human and so disconnected for being members of our church (L.I.C). Another participant E from (M.C.A.N) said:

> When you are sick and ask people to come and help you in the house, no one is willing to come over. People in community think we are members of the church of Satan and they fear us, they can't help with anything.

The attitudes of people in communities or neighbourhoods segregate, label and marginalise people in L.I.C and M.C.A.N churches; therefore, equipping caregivers (leaders and members) involved in care enables them to address issues members face daily.

5.4 Poor children of God theology, spirituality, and mental health

From the empirical study, members of L.I.C identify themselves as *batambi ba Jehovah* (thepoor of god). This is based on the belief mentioned earlier in chapter 1. The leadership of L.I.C embraced a theology of poverty, and normalised lack of assets or wealth among the members. Members of the church embrace poverty and as soon as they are converted, they sell all their property in their communities of birth to join the community of believers in Jehovah Wanyonyi and practice living on one purse as the early church did. Members are unaware of what such commitment holds, and as they sell all they have, they end up sharing the little they get as a community while living together. What they do not understand is the impact of material lack on their physical, social and psychological well-being, for instance due to lack of basic needs, people

worry, get stressed up or even become sick due to poor nutrition. What the participants were not conscious of is the economic aspect of church membership. Participants shared that they sold everything and brought
proceeds to L.I.C. When they did manual jobs, they brought all proceeds to Jehovah Wanyonyi So, they become a source of income to the spiritual leader who decides to take the high percentage and give the remaining to the participant. In M.C.A.N, *Nabii* decides to apportion any amount on the gifts and decides the best animal to be brought for sacrifice. Similarly, pastoral caregivers and pastoral counsellors ought to understand this so that they can also help in proper interpretation of scriptures and use of scripture in real-life situations. More so, care-seekers ought to be assessed and supported with pastoral care and pastoral counseling to ensure mental health care caused by the stress and anger members have to put up with for a long time. This will take care of clinical conditions which for instance are mental ill health, is spiritualised.

5.5 The need for an alternative pastoral care and counseling model

The majority of participants were happy with the services they receive, but they also indicated that more needed to be improved to equal the standard of other churches around them. The need for training, exposure and improvement of care further necessitates a different model. This is why a model for Biblical pastoral care and pastoral counseling comes in handy to show how caregivers could appreciate positive therapeutic relationships, particularly the creation of rapport by the caregivers. Building relationships motivates the care-seeker to share, and assists in appropriate use of religious Christian resources including alternative rituals and God image. Skills in pastoral care and pastoral counseling make it possible for caregivers to apply functions of pastoral care, and to apply counseling skills of listening, empathy, unconditional positive regard, trustworthiness while applying pastoral ethics.

The quest for care in L.I.C and M.C.A.N and alternate care emphasised the need for an integrated Biblical pastoral care and pastoral counseling model to address the needs of participants. The proposed model will create therapeutic relationship, professionalism, faithful praxis in pastoral care and pastoral counseling, which values centrality of appropriate interpretation and use of scripture.

This study identified the inefficiency and inaccessibility of inter-church pastoral ministry based on divergent theological emphasis and doctrine, and application of religious resources in mainline churches and A.I.Cs. Whereas churches like the Anglican church of Kenya, Reformed church of

East Africa, and the Presbyterian church of East are places that some members from L.I.C and M.C.A.N would access needed pastoral care support, their beliefs and faith are different. In mainline churches faith in the almighty God, the finished work of Jesus Christ, use of Christian scripture, church space and trained and or ordained church workers are different from L.I.C and M.C.A.N. Strict loyalty to L.I.C different deity (Wanyonyi for L.I.C) and founder of M.C.A.N (Nabii Yohana), insistence on animal sacrifices in both L.I.C and M.C.A.N (when mainline churches have at the core, the finished work of Jesus Christ on the cross) variances stand in the way of inter-church pastoral care service provision. L.I.C and M.C.A.N unique visit to sacred spaces different from the mainline church spaces (shrines, altar, rivers), use herbal medicines, oils, and have total loyalty to founders of the congregations, explains their different doctrines and understanding of relationship of deities and humans. The difference makes L.I.C and M.C.A.N congregations not readily access care in Mainline churches, and yet their ways to care for members of congregations leave them to seek for help outside.

5.6 The role of interdisciplinary models in care and counseling – Interpretive task

Earlier on in chapter 3 the researcher presented literature on views of known and documented psychological and pastoral care and pastoral counseling models; thus REBT (Corey, 2017:8, Kiriswa, 2014:13, Louw, 2016:429) Egan – Skilled Helper (Egan, 1998:7-8, Nelson, 2007:1), PCT (Kiriswa, 2014:14-16, Mearns & McLeod, 2013:52, Wilkins, 2003:7-21; Rogers, 1967), African traditional models (Gichinga, 2007:9; Kiriswa, 2014:29-31), Psychoanalytic (Corey, 2009:60-69; Jacobson, 2013:1; Kisiswa, 2014:13) and biomedical models (Louw, 2008:37-39; Chemorion, 2009:56-61; Lakhan, 2006:1-2); Four-Stage model (Louw, 2016:523-527); and Biblical Pastoral model (Breed, 2015; Pretorius, 2017:205). This study used the Four-Stage model and Breed's Biblical model to develop a model for care of people involved with faith healing within belief systems.

5.7 The Four-Stage model principles of Louw

The Four-Stage model addresses those skills and pastoral functions that caregivers need to make pastoral care and pastoral counseling effective.

5.7.1 Pastoral skills and functions

Therapeutic skills are core to Louw's Four-Stage model. In his model, Louw states that the use of

therapeutic skills such as listening, acceptance,[80] understanding and empathy in therapeutic relationships are of paramount importance since the skills help caregivers to not only engage care-seekers and show respect in pastoral care and pastoral counseling, but to also gain clarity, exercise sensitivity and express compassion to care-seekers.

It is also important for pastoral caregivers to apply the pastoral functions that are given for use in care. Pastoral functions such as facilitating, sustaining, guiding, healing and nurturing, reconciling, confronting and interpreting are foundational in a pastoral therapeutic relationship. The pastoral skills and functions are utilised at different, if not all, stages of the Four-Stage model as set out below.

5.7.2 Stages of Four-Stage model

5.7.2.1 Building trust and sharing

The first principle in the Four-Stage model is trust-building and sharing (affective). In this principle, building trusting relationships helps caregivers and care-seekers in self-awareness in the world of experience, creates safe space for disclosure and makes room for exercising appropriate communication[81], offering acceptance and unconditional love to the care-seeker.

5.7.2.2 Consideration of options

The second principle is consideration of options (cognitive). Here the caregiver helps care-seekers to engage in facts, and to reflect on meaning at a rational level, be actively involved and explore available possibilities and to make appropriate judgments concerning issues affecting them.

5.7.2.3 Decision making and responsibility

The third principle is decision making and responsibility (conative). Care-seekers in this principle are to be encouraged by the caregiver to own goals that involve personal actions.

[80] It is said that helping begins with acceptance of care-seekers just the way they are. This is a key ingredient for creation of atmosphere for change, growth, and one's willingness to confront the world. Being accepted for some people seeking care makes them feel release from negative effects of threat (Combs, Avila & Purkey, 1978:148- 150).

[81] Communication must be related to the need of care-seeker relationship of information to need, meanings, information in the field, and openness of the field at the moment of communication in care (Combs, Avila & Purkey,1978:164-172)

5.7.2.4 Goal setting

The fourth and final principle is goal setting that has a spiritual dimension (hope) that deals with integration and meaning making. The caregiver imparts meaning through wisdom by using spiritual resources, while the care-seeker gains meaning by maintaining faith.

Therefore relationships, consideration of options, decision making and responsibility, and goal setting on the part of the care-seeker, as a spiritual dimension of hope, is key in the Four-Stage model and is linked to the principles of care in Breed's Biblical Pastoral model that I will turn to in the next section. Both the Four-Stage model and Breed's model are essential for formulating a model for pastoral care and pastoral counseling with a view to assist people involved with faith healing within belief systems.

5.8 Breed's Biblical Pastoral model

The pastoral model proposed by Breed has core aspects which are useful in the formulation of the integrated Biblical pastoral care and pastoral model. In this model relationships are considered important. Breed contends that God created humanity to be in vertical and horizontal relationships – relationships with God, with humanity and with all creation. God, through intimate relationships with his creation, cares and provides through his grace. Human deficient relationships are without God and are void, empty and lonely. And through good ecological relationships, humanity protects and nurtures creation. God-human relationships are important because without them, humanity deficiency sets in and there is fear, emptiness, and pain, and attempts to heal lasts for a brief period due to the fall. It is God through God-human relationship that can provide a lasting relief of human pain.

5.8.1 Breed's theoretical framework

The theoretical framework in this model is extremely useful for pastoral caregivers and is embedded in:

(a) God – Knowledge of God the Father (the first Person of the Trinity) and his grace through which humanity receives unmerited love, lowers human anxiety and defensive behaviour. Knowledge of God as the Shepherd guides care-seekers to the knowledge that in God and through God, they will lack nothing, as God will supply in their needs, protect them and provide that they will enjoy steadfast love, as pointed out by the psalmist in Ps. 23:1-6.

The second Person of the Trinity – The Person of Christ, is key as care-seekers faced with brokenness regain their identity created by God. In their challenges care-seekers are restored, strengthened, encouraged, loved and they feel accepted by God.

The third Person of the Trinity – The third Person of the Trinity is equally important in care: The Holy Spirit – the Comforter, from Greek *Parakletos* (Jh. 14:16), helper, advocate and supporter assist care- seekers and gives them relief. As a guide, the Holy Spirit leads care-seekers to understand the truth and enables them to gain insight into the truth of God (word in Scripture) continually. The Holy Spirit also empowers care-seekers to love and obey Christ and use the truth of scripture as they face difficult situations in life. They are empowered with courage to overcome the challenges. Therefore, the trinity gives care-seekers a sense of belonging, love, comfort, protection and courage, and in the Holy Spirit care-seekers find acceptance.

(b) Prayer as a spiritual resource leads care-seekers to communicate to God so they can experience joy and peace in the conversation with God. This affords care-seekers an opportunity to reflect on God's goodness, as the caregiver guides them to understand God's truths.

(c) Christian Scripture – this is a central spiritual resource from which pastoral care and pastoral counseling is done. The word of God comes live and is heard anew by care-seekers as they are guided to understand the truth in it and supported to apply it in life, and remain open to hear God through Scripture.

5.8.2 Process of Biblical Pastoral model

Through the Biblical Pastoral model, Breed gives a four-task/-phase spiral that is related to that of Osmer that demonstrates the process in the journey of pastoral care. The questions asked, and responses to each are as follows:

1. What is going on? - Listening to discover what is going on.
2. Why is this going on? - Understanding/visualising.
3. What ought to be going on? - Seeing what is going on/happening.
4. How might we respond? - Leadership – planning ways of addressing the

situation.

Breed's model is built on principles and steps that I now explain in the section that follows.

5.8.3 Principle of relationality – Step 1. Relationship and data gathering

Build pastoral relationship/rapport characterised by unconditional acceptance, love, understanding and trust during which the caregiver joins the care-seeker in conversation with God. Exploration of lies takes place and the lies are replaced with truths from Scripture.

5.8.4 Principle of true convictions – Step 2. Coram Deo

This phase entails living in trusting the Lord in horizontal and vertical relationships (man-man, God-man) where the care-seeker confronts the law of God, proclamation of God's grace and experience of the unconditional love. The care-seeker is assisted to use Scripture to explore one's own lies (false conviction), replace them with truths, and apply them in life, while bringing God of the Word into the pastoral conversation through prayer, The care-seeker also communicates directly with God and comes to know God's love and comfort, and experiences strong intimate relationship. and communion through the Holy Spirit in reality. In this phase we see an example of accountability partners who remind care-seekers of God's grace and commandments and assists care-seekers to confront false convictions with truths (Breed, 2015).

5.8.5 Compliance principle – Step 3. Obedience

During this phase, the caregiver assists the care-seeker in breaking from false convictions, lies in their lives, to form new convictions as they integrate truth in their decisions, behaviour or habits. This calls for commitment to learnt truths and belief in word, and practice of works of service. And through the cycle of grace, the care-seekers have renewed hope (Breed, 2015).

5.8.6 Accountability principle – Step 4. Support and follow-up

Phase 4 is a continuation of phase 3 above, and during this phase, caregiving moves from caregiver as counsellor/pastoral caregiver to the community of believers for continued support and growth. During this phase, accountability of pastors/counsellors/caregivers is ignited, where the congregation assists, prays and heals care-seekers through faith community support networks (Breed, 2015).

5.9 Exegetical work done on Mark 5:25-34 principles, values and perspectives for pastoral care and pastoral counseling – Normative task

In an earlier section, the researcher indicated that the study will, in the normative task, explore the Biblical principle perspectives on pastoral care and pastoral counseling for people involved with faith healing within belief systems. The study used the pericope in Mark 5:25-34 to achieve the aim of this task. The healing of the woman with the flow of blood falls within a 'sandwich' in which two people are cared for by Jesus in the Markan community – the Roman Officer's 12-year-old daughter who was ill and later died, and the woman who had suffered for 12 years from a terminal condition of the flow of blood. The healing values, principles and perspectives will be drawn from the pericope that outline the healing encounter between Jesus and the woman with the flow of blood located in the pericope of Mk. 5:25-34.

5.9.1 Principle #1 Weaving of community healing Narratives

The historical critical exegetical work done on the pericope in the gospel according to the book of Mark showed various healing needs in the Markan community. The events before and after the select pericope, Mark 5:25-34, showed the connection of the healing of the outsider (woman with the flow of blood) to the insider (12-year-old girl) daughter of the Roman officer in the larger pericope Mk. 5:12-43 by the same caregiver – Jesus. This is referred to as a 'sandwich' narrative in which the healing of the insider depended on the healing of the outsider. The healing of the woman who was not from the Roman officer's circle, determined the healing of the 12-year-old daughter of the Roman officer. This is critical, as the healing and care of the L.I.C and M.C.A.N members are also linked to other members in other churches, and Jesus Christ the source of the healing whose power is accessed by people regardless of their affiliations. Similarly, faith on the part of the care-seeker and its trust and connection to the healing power (Jesus) and willingness in a therapeutic relationship by Jesus was critical. The following key principles and perspectives relevant for pastoral care and pastoral counseling emerged from the exegesis.

5.9.2 Principle #2 Relationships in therapy

The gospel of Mark shows the need for a relationship between God and humanity. The relationship between Jesus in the text and the woman with the flow of blood is a clear need of connection between the believer in need of care or healing with Jesus through whom full healing can be found. Also important is the attitude of Jesus towards the sick, lonely, unprotected woman ritually unclean and unworthy. He provided a trusting relationship, recognition, empowering and confirmation of the healing that had taken place. The pericope also revealed the invitation of Jesus to the woman who had been healed. This invitation creates safe space for care-seekers to feel accepted, and given freedom to share embarrassing, ashaming or uncomfortable issues in life

5.9.3 Principle #3 Invitation and intentional concern

Jesus' invitation to the woman occurred when he asked who had touched him. This enabled the woman amid the fear, to feel welcome to share her story to Jesus, as those who thronged around Jesus heard the testimony of what had happened. The invitation confirmed healing, afforded the woman the opportunity of confronting her fears, sharing her story fully, and also giving the community the opportunity of witnessing and learning the impact of faith in the God who heals.

5.9.4 Principle #4 The God-image and faith

Care-seekers need to have a clear idea of who God is in their lives, what he is able to do and have a connection with God through Jesus through whom God reconciles his people back to himself. This principle especially helps when care-seekers have the knowledge of God through Jesus Christ, that will make them to trust in his power to save one in need of deliverance from not only a terminal condition but all social, cultural, or religious-related conditions affecting humanity. Care-seekers are reminded that they receive healing through the Grace of God that manifests the health seeker's faith and belief in God and Jesus. This principle also teaches that care-seekers should have faith in and belief in the healing and saving power of God for they have direct access to the healing power. The benefit of connection with God and his healing power makes care-seekers, like the woman in the text, to risk breaking the cultural barriers in order to communicate with Jesus and be healed.

Care-seekers need God in whom cultural or religious polarities of any kind are united; a God who makes people discover their potentials as full individuals and humankind, and not defined or limited by their needs.

5.9.5 Principle #5 Participatory care

The role of the care-seeker in the pericope is crucial because Mark shows us that the action and initiative of the health-seeker is important. Here the care-seeker intentionally exercises his/her faith like the woman in the pericope who acted out of faith when she needed healing. Care-seekers are encouraged not to lose faith in the healing power of God through Jesus. They are also encouraged to identify the true source of an ultimate solution to healing such as a 12-year-old problem that had drained the woman's social and financial resources. The attitude of the woman showed that she was aware of healing and the source of healing and was fully convinced that through touch, and interruption of the caregiver on a healing mission would heal her as well. This is key in pointing out the role of care-seekers in a therapeutic relationship; that of participation and not being on the receiving end, which is critical. Even when nothing seems to be working, care- seekers are to trust in God for strengthening them in their quest for healing.

5.9.6 Principle #6 Care skills and values

Care-givers ought to use competent pastoral skills modelling the responses of Jesus to the woman with the flow of blood who touched him. Jesus' responses were characterised by knowledge of the care-seeker, affirmation of her faith, encouragement, kindness, caring support and empowering, which led her to tell of her story (testimony), which led to full recovery.

5.9.7 Principle #7 Genuineness and restoration to wholeness

The principle of genuine therapeutic relationships for wholeness should be encouraged throughout pastoral caregiving. Similarly, caregivers should show how the outcome of care should be. Furthermore, the need exists for collaboration with others to ensure that care-seekers are restored to good health, and that their lives are made whole, filled with peace in their quest. Pastoral caregivers should care and counsel care-seekers so that they can attain wholeness that frees people to discover their personhood, and ability to see themselves as whole persons. The pastoral caregiver should be aware of the deeply embedded cultural stereotypes that undermine competent caregiving. The pastoral caregivers should strive to care for and counsel to care-seekers who feel alienated from church or feel threatened by church structures to find wholeness.

5.9.8 Principle #8 Liberation

Caregivers are supposed to free care-seekers from any condition that oppresses them and denies them peace and excludes them from the community. Jesus liberated the woman who suffered from the flow of blood, a condition that made her ritually unclean and totally cut her off from the community. Due to that, she suffered shame and restriction of movement for she was considered unclean, because of her condition that was seen as contaminating. Care-seekers are to be helped by liberated pastoral caregivers to define their potential rather than letting them suffer due to assumptions and expectations of society defining them based on gender or physiology.

5.9.9 Principle # 9 Integration back into the community

Caregivers are encouraged to understand that the process of healing does not stop with the healed, but involves the integration of the healed back into the community of which the care-seeker is a member. The principle of integration back into the community is critical for continued care and support by community members and the church community. The process of healing that involves cleaning provides for re-entry into the human community, and most importantly, acceptance into the kingdom community. Through new relationships characterised by love, compassion, caring, service and nurturing, the caregivers and care-seekers enable the care-seekers and community to experience and enhance wholeness.

5.10 Amalgamation: empirical research, literature, models and exegesis of Mark 5:25-34

The merger of data from empirical data, literature review data and the historical exegetical data will give us a comprehensive and representative report on the experiences of L.I.C and M.C.A.N, research done elsewhere on AICs, and the Biblical principles that inform formulation of an integrated Biblical pastoral care and counseling model. The process of amalgamation will also show intersecting and divergent points that illuminate the model for a pastoral care model to people with faith healing within belief systems in L.I.C and M.C.A.N.

5.10.1 Interpersonal Relationality

Some participants shared that their relationships with others and God as being as follows:

‘Sometimes I am lonely as one with mental health, nobody cares ….’

The principle of relationality is shared among the Four-Stage model, the Biblical Pastoral model and the exegetical piece in Mark 5:25-34. This emphasizes the need for having horizontal and vertical relationships between the caregivers (who may be pastors or leaders in the churches) and God, and also to nurture a human-to-human relationship between the caregiver and the care-seeker in pastoral care and pastoral counseling. However, the participant experiences differed, as shared below:

> I have no one to talk to in church, we keep silent. When I ask for help in school, or community, I am told I am denied, I face stigma and ridicule; people tell me to ask my god Jehovah to provide**.**

Another participant said:

> My relationship with God is good, but I am only blessed when I obey all rules and commandments. If I do not, I am not blessed, so I try to obey.

The pericope Mark 5:25-34 moves further to show us the importance of extending our relationships to others outside the community of faith since healing is also connected to them. People in the life or community of the care-seeker who form a support system, are vital in care. The human-to-human relationship experience of participants was different. Another participant said that there are broken relationships; thus

> I am lonely, as one with mental heal, nobody cares for me….it hurts whenI live alone, when people move away from me.

Through mutuality in human working relationships in care and counseling, the caregiver can exercise warmth in welcoming the care-seeker and making him/her feel at home. The environment created is safe and not only invites but motivates the care-seeker to express his/her challenges clearly. In the empirical study, participants indicated struggling with relationships at a personal level in the process of seeking care and in the community. The caregiver can take advantage of building relationships through rapport so that care-seekers can feel safe and encouraged and share, but at the same time nurture good relationships in the family, the church and the community. Caregivers can also use the pastoral functions and pastoral counseling skills to engage the care-seeker to explore, clarify and gain an understanding of the issues confronting them.

5.10.2 Knowledge of better care options

Participants had knowledge of care options in their lives, but one said:

> Sometimes I sell all animals and I still feel pain and sick for long…uh, so I go alone to uh…. the traditional doctors in the community to help me to see what is wrong.

Prayer also seems important, and another participant said:

> Whenever I am so disturbed, bad thoughts and dreams coming, I don't go to Nabii. I go far to communities away to look for people who are strong prayer worriers. Then I feel better after 2 or 3 days.

Whilst pastoral caregivers guide people, people find solutions to their challenges from other care options. Some of the options indicated above are disconnected from the reformed and Christian understanding of faith, of God and prayer, and their place in healing. The known options disconnect care-seekers from God; hence it leaves them with the option of depending on another human being to solve their challenges. It not only reduces trust and reliance on God but also fosters dependency on people who pray for them.

Principles that guide caregivers in the Four-Stage and Biblical Pastoral models place emphasis of knowledge of God and clarity on the human situation during pastoral care and pastoral counseling. Knowledge of God is anchored in faith in him and his steadfast love, grace and peace that helps the caregiver minister hope of the ever-present caring God in whom long-term solutions to human challenges can be found. Mark 5:25-34 clearly exemplifies how connection to God, through Jesus Christ, translates into connection to the source of healing power whose healing outcome is permanent. Before the woman in the pericope was connected to Jesus – the second person of the trinity, the woman was in pain, frustrated with physician care, and when she finally opted to connect to Jesus through faith, God permanently solved her challenge.

Caregivers should also gain clear facts from Scripture and of the context of the care-seeker, as they work to assist the care-seeker, motivate participation of the care-seeker, and use spiritual sources, especially truth of Scripture as a guide to separate true convictions from false convictions that lead to challenges. Through correct convictions, the care-seekers may have a clear idea of who God is – whatever they perceive God to be. For instance, one who is present with a care-seeker, identifies with him/her – alongside-ness with God, one who gives rest (Ex. 33:13-14), labouring together (5:16-6:10), alongside (incarnate) (Heb. 1:1-4). The presence of God does not only pervade all lives of care-seekers' relationships but through presence it generates changes: in God through Jesus Christ, we have a new identity, and are made family, in a closer relationship with God who cares for human needs (Mk. 5:25-34).

5.10.3 Decision making

One participant said:

> In my church, I just follow what Nabii says…he knows about my problem, and answers. Again, we are taught not to question the man of God…. what he tells me about my problem, what to do and I follow.

Another participant said:

> I call *Mama Kanisa* when I have issues…and uh…so she comes and prays and opens Scripture, reads and interprets my issue. She tells me what is bothering me and what God says. Mine is to listen and do as she tells me.'

Situations of care for participants present the need to make decisions. In some contexts of care in the two churches (L.I.C and M.C.A.N), decision making opportunities are lost, especially for limited use of truth from Scripture. In such cases, the role of the care-seeker in pastoral care, as one to be supported to make correct and informed decision, diminishes when the caregiver makes all decisions.

5.10.3.1 God image and use of Scripture

A participant said:

> God cares and loves us in church, and he appointed *Nabii* and gave him the power to heal us.

Another participant added:

> *Mama Kanisa* reads the Bible and tells me what God says about my problems, and prays over me. What she says I believe and follow.

Diverging understandings of Imago Dei prevailed, as participants believe in a different deity (for instance the human deity in L.I.C) other than the known Christian God where emphasis is on both anthropomorphic and divine aspects and have total loyalty to him.

> Jehovah, *muumba mbingu na nchi* – creator of heaven and earth, is my god, he is good and cares for me, and forgives my sins, and blesses me when I obey commandments.

The M.C.A.N practice believe in the Christian God, but like some other A.I.Cs, the adherents have faith in the healer. Similarly, there was selective use of some sections of Scripture commonly used by caregivers in L.I.C and M.C.A.N, for instance where preference is given to the OT other than

the whole Bible in L.I.C. However, alternative Scripture was used (which includes extra 30 non-canonical books by M.C.A.N. The other aspect that affects decision making includes some biased non-formal approach to counseling and pastoral care.

The Reformed tradition as referred to in this study believes in both the Old Testament and the New Testament as the word of God and stresses the need for faithful interpretation and application. From the exegetical work on the pericope, we see that the bible Bible provides guideposts and principles that church caregivers, among whom are pastors, could turn to for authoritative directives for the congregational pastoral caregiving and pastoral counseling.

The Bible is related to circumstances of the changing conditions of human life; therefore, it is important to look at the basis for principles inherent in the situations. A responsible use of the Bible is basic to the performance of constructive pastoral counseling and can provide needed principles whereby the minister may evaluate on-going pastoral work and make constructive use of data that have emerged from behavioural sciences (William & Oglesby, 1980:11).

5.10.4 Faith and communication

A participant said:

> In my church, we have faith, and we totally trust Nabii and his healing because he was appointed by God.

Another participant said:

> When I joined, I was told by the high priest that faith in Jehovah is important. Moses taught the Israelites, so I was told I obey the law, commandments and what Mama Kanisa says when reading the bible'.

Decision making, maintaining faith in God, communication and clarification of true convictions based on truth in Scripture is important in pastoral care and pastoral counseling. Verbalising clarity on the belief one has about the ultimate being and reality, source of healing and belief in the power of the deity is critical in pastoral care and pastoral counseling. Faith is connected to trust and hope for better, even when the circumstances are challenging. Furthermore, the caregiver should help the care-seekers to be clear on personal accountability and decisions to be made concerning the situation or challenge. Caregivers help check the behaviour of the care-seeker so that his/her behaviour is in line with true convictions as guided by Scripture.

5.10.5 Community and support system for wellness

A participant said,

> When neighbours see us on the road, they run away …they just fear us…and say we are devil worshippers.

Another participant said:

> I wake up very early to go for assistance when I feel unwell, and when I get the herbal medicine, I come back late when people don't see me, uh…and I don't talk to anyone.

Another participant said:

> It is only people from my church who visit us at home. People in the community never visit or send any help…even when we are sick. People ridicule us and say, ask your god to heal you.

A great need exists for pastoral care and more support systems for care-seekers who feel segregated. Through pastoral care and support systems in the church community, the care-seekers experience renewal of hope and reconnection with the faith community resources for support and follow-up. In the empirical study, MMR showed that community was critical for providing some alternative care and support system readily available, however minimal the support would be. The literature review showed that Louw, in the Four-Stage model, and Breed, in the Biblical Pastoral model, also highlighted the role of the community as a source of support and follow-up. Similarly, the exegetical work on Mk 5:25-34 underscored the need for the community for reintegration of care-seekers once they are healed. Communities in Africa play very important roles concerning care and linking pastoral care and pastoral counseling with community care and support systems promotes community healing and wellness in Africa. The communal care and support systems are accessible and are enjoyed by care-seekers, since care-seekers' struggles are shared in the community, and when healing is realized, it is communicated beyond the individual. Reconnection with the community ensures holistic healing since the healing of the individual translates into healing and overall harmony and wellness of the community. Where non-functional relationships exist in the community, pastoral caregivers can work with members to redeem the communal support system to be there for the weak, the sick and the challenged.

5.11 Proposed integrated alternative pastoral care and counseling model: pragmatic task

We earlier saw in chapter 1 section 1.1.4 that pastoral care is the total care of the church members and all people with whom they come into contact. We further saw that pastoral care is also broad and all-encompassing of shared healing and growth within a congregation (McKveer, 2019:9) Pastoral counseling was seen by Clinebell (1984:24) in section 1.1.5 as the utilization of a variety of methods to assist people in dealing with their problems and crises more effectively; thus healing brokenness. The integrated pastoral care and pastoral counseling model proposed guidelines inan endeavour to capture the spirit of holistic healing of people with care needs.

The principles in the models of Biblical Pastoral care model, the traditional African Counseling model and the Four-Stage model bring under discussion the empirical findings of the study, particularly the strategies of care employed by the L.I.C and M.C.A.N churches. The researcher looked at the historical critical interpretation of the pericope, Mk. 5:25-34 and identified 'principles and practices'[82] of care that guide the model of integrated Biblical pastoral care and pastoral counseling for people involved with faith healing within belief systems in L.I.C and M.C.A.N. This entailed reflecting on the empirical studies done and the Biblical interpretation of the pericope in Mark 5:25-34 action plan and undertaking specific responses that seek to shape the episode, situation, or context of the L.I.C and M.C.A.N in desirable directions.

From the literature review, the empirical research and exegetical work, the study found principles around common themes that will be used to propose the alternative integrated model for pastoral care and counseling for people involved with healing within belief systems in L.I.C and M.C.AN. The care-seeker's appropriate image of God – the care-seekers are to clarify their God image; thus be clear on who God is; one who loves, cares and heals. In care, a need exists for genuine connections between the care-seeker and caregiver, and God. It is to be understood that exclusion of God disconnects the care-seeker from the source of healing power. Similarly, a need exists for comprehensive scriptural truth, use of Christian and communal healing resources, active involvement in decision making, spiritual and cultural competence, liberation, restoration, reintegration and ensuring hope care. This is explained in the following table.

[82] The nine key Biblical principles in the select pericope of Mk 5:25-34 include: weaving of community healing narrative, relationships in therapy, invitation and intentional concerns, the God-image and faith, participatory care, care skills and values, genuineness and restoration, liberation, and reintegration back into community (see 5.6.1-5.6.9).

Table 5-1: Proposed integrated alternative pastoral care and counseling model

	Principles and values	Details of pastoral description
1	God Jesus Christ Holy Spirit Total healing steadfast love wholeness faith/grace dependency	God image – Have faith and trust in the triune God and in the healing power of the supreme being through which we access the mercy, steadfast love, healing, and wholeness
2	Connections/ relationality rapport Empathy Compassion Guidance pastoral skills	Connections and relationality – building genuine therapeutic relationships where the caregiver invites the care-seeker and assures the care-seeker of support and guidance, allowing the care-seeker to share, so the caregiver can care.
3	Scriptural truth appropriation interpretation application	Comprehensive Scriptural truth – read and discern the will of God for care and healing through proper use, interpretation, and appropriate application of scripture in the context of pastoral care and counseling.
4	Community and spiritual resources hospitality/material skills/people symbols/wisdom space/rituals	Christian and communal resources – to use all Christian and spiritual recourses and tap in on communal resources such as hospitality, availability and willingness to care, and a readily available support system. Cultural and spiritually competent care. The caregiver utilises the knowledge and skills and pastoral functions, community values, wisdom, and spiritual resources to achieve pastoral care and the pastoral counseling objective. Use of alternative Christian rituals and community leaders
5	Active participation priorities solutions decisions choices	Active participation –care-seekers as well as caregivers are involved in priorities and solutions – guidance (caregiver), and decisions and choices (care-seeker)
6	Restoration reintegration reconciled re-membered healed relationships preferred option	Restoration and wholeness – The end goal of pastoral caregiving and pastoral counseling is restored to better functioning as an individual and member of the church and the community.

	Principles and values	Details of pastoral description
7	Pastoral competence knowledge professional skills and cultural values, wisdom	Use of pastoral knowledge, skills and cultural values and wisdom in context – sensitivity to cultural context, displaying professionalism and applying local values and wisdom. The competence aims at the care of the physical, social, psychological, material, and spiritual – the complete person.
8	Liberation affirmation release, solutions /confronting lies. Deliberate choice /direction Reconciliation	Liberation – Deliverance from challenges and issues that impact the care-seeker and guide towards solutions, choices and/or alternatives Care-seeker re-affirmed – caregiver to the care-seeker ought to deliver challenges, confront lies with truth, choose better alternatives
9	Reintegration Reconciled, re-membered, healed relationships. preferred options	Re-entry into community Family and church with healed and working relationships
10	Hope building Dreams, and expectations Assurance and trust positive living /Growth	Hope Care – build hope of moving on together with the community (family, church, community), and with God
11	Community wholeness transformation shalom/well-being/fullness of life and reunion	Community thriving where there is reconciled, healed and overall wellness in horizontal and vertical relationship (care-seeker-God, Care-seeker-creation and human community)

The integrated pastoral care and counseling Model centres on the triune God, steadfast love, faith, grace and dependency on God in relationships, scriptural truth, active participation, community, pastoral competence, liberation, restoration, hope building and reintegration into transformed wholeness and wellness.

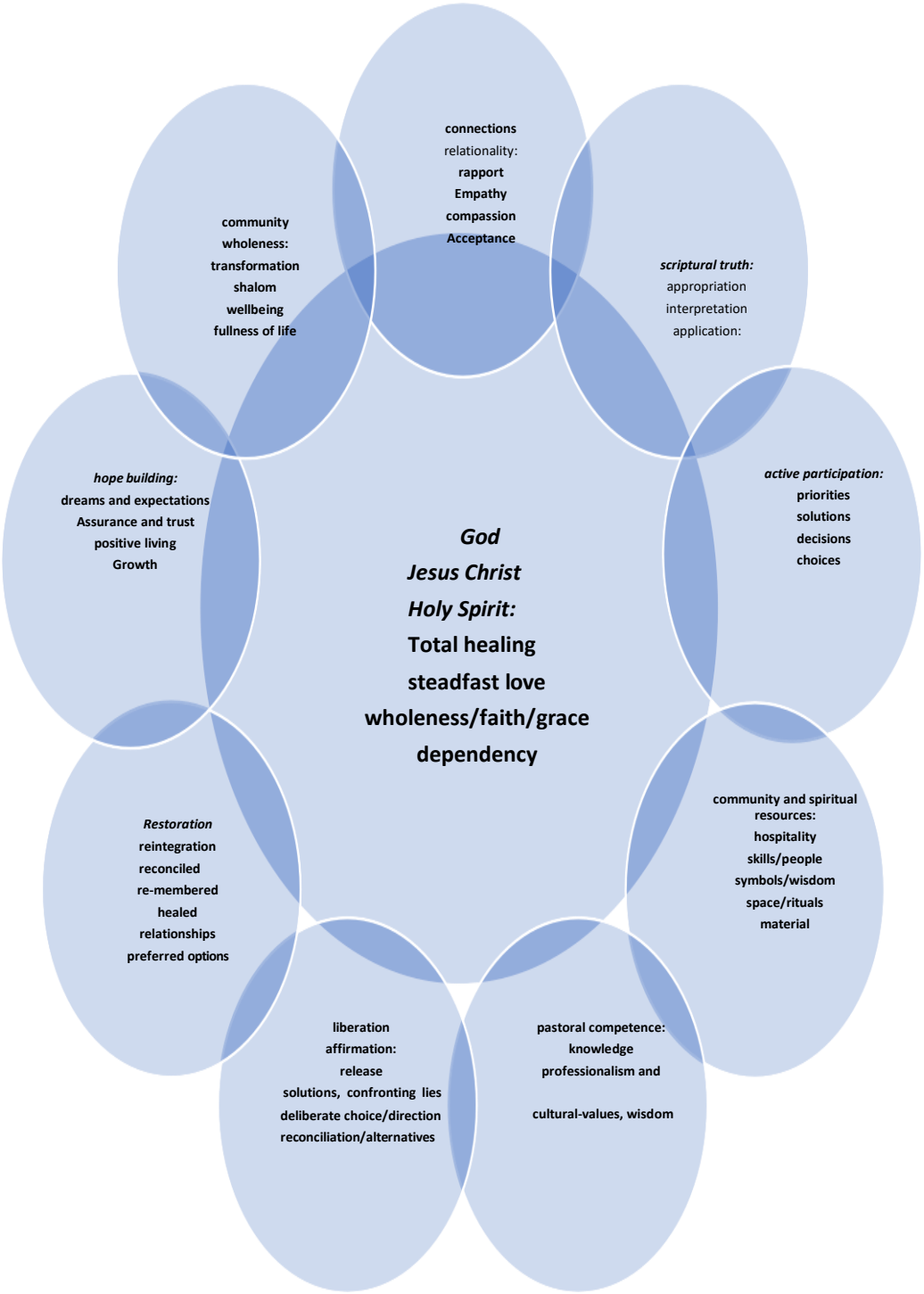

connections
relationality:
rapport
Empathy
compassion
Acceptance
community
wholeness:
transformation
shalom
wellbeing
fullness of life
scriptural truth:
appropriation
interpretation
application:
hope building:
dreams and expectations
Assurance and trust
positive living
Growth
active participation:
priorities
solutions
decisions
choices
God
Jesus Christ
Holy Spirit:
Total healing
steadfast love
wholeness/faith/grace
dependency
Restoration
reintegration
reconciled
re-membered
healed
relationships
preferred options
community and spiritual resources:
hospitality
skills/people
symbols/wisdom
space/rituals
material
liberation
affirmation:
release
solutions, confronting lies
deliberate choice/direction
reconciliation/alternatives
pastoral competence:
knowledge
professionalism and
cultural-values, wisdom

Figure 5-2: Proposed integrated alternative pastoral care and Pastoral counseling model

The integrated alternative pastoral care and pastoral counseling model has the triune God at the centre of caregiving.

1. The 'God-image' principle is core and is shared by all other aspects of care. The sharing in principle 1 is linked to/overlaps the next principle which overlaps the third and this overlapping follows through until all principles are completed. The Triune God is the constant factor in which every principle is anchored as it is connected with a rippling effect to the principle that follows next. 'Steadfast Love (Ps. 36:7), faith (Heb. 11:6), grace (Eph. 2:8) and 'dependency on God' (Prov. 3:5-6) characterize this principle of which the ultimate aim is wholeness.
2. The second principle grounded on God image is 'relationality'. Warmth, welcome and acceptance resulting in a rapport allows story sharing in caregiving (Mk. 5:32).
3. The third principle is 'Truth' based on scripture, grounded in the triune God, gives guidelines for day-to-day care and illumes people's thoughts and desires so they can gain clarity on what is true in life and make the right decisions based on truth (Jhn. 8:31).
4. The fourth principle is active participation of the care-seekers and the caregivers in the process of pastoral caregiving. The decisions on making priorities of needs presented by the care-seeker, solutions to the challenges and freedom to make choices revolves around the leading of the care-seeker under the guidance of the caregiver.

5. The fifth principle on resources for pastoral caregiving is referred to as 'Community and spiritual resources'[83] that enable caregivers to attend to the needs of a care-seeker's needs that are to be identified. These may be community values, wisdom, skills, willingness to support caregiving within the context of the care-seeker and caregiver. It may also include hospitality where community members are ready and willing to offer their time and resources and welcome to the challenged person. They are also ready to encourage or give material support for basic human needs so that they minister to the complete person. Caregiving skills and availability of family members, the community, or church leaders to be present in the lives of people. Religious or

[83] This involves all pastoral functions and pastoral care and pastoral counseling knowledge and skills (such as guiding, sustaining, nurturing, reconciling, attentive listening, empathic understanding, clarifying and probing among others).

spiritual resources needed in caregiving are important. Space (sacred-like church), rituals, wisdom from scripture, religious leaders, symbols, prayers and presence make it possible to take care of the needs through pastoral care and counseling. Christian rituals such as baptism, confirmation, holy communion, anointing, amongst others, and material support (food, clothing shelter) make pastoral caregiving profound since all needs of care-seekers are attended to.

5. The sixth principle is pastoral competence. This entails training where the pastoral caregiving team acquire knowledge and skills and become acquainted with the cultural values and wisdom so that they can competently care for all the needs of the care-seeker in a professional/informed manner. This includes exposure to the appropriate use of pastoral skill, knowledge and spiritual resources.

6. The 7th principle is liberation of the care-seeker. In this case, the caregiver affirms the care-seeker while releasing the care-seeker (deliver) from whatever challenge was making the care-seeker to not function well. A new solution, deliberate choices and direction is reached at. This brings transformation in the state of being, where the care-seeker is better while still connected to the source of power that heals and brings about positive change. False convictions previously subjugating the care-seeker are identified and challenged with the truth in scripture. The care-seeker is affirmed and alternatives to care are reached at.

7. Restoration and reintegration, principle number eight, concerns gaining back the former state of functioning well within oneself and the surrounding. Here the care-seeker is reconciled to him-/herself, God and the community and made a member again (re-membered) in the life of the community, and preferred options are workable. Relationships in this principle are healed and restored all round.

8. Hope building is the ninth principle where the caregiver supports the care-seeker to walk towards the dreams and expectations through assurance and trust building towards the connections expected in the community. This includes release for living positively to experience growth in the community of faith and family within the support network while remaining connected to the centre (triune God).

9. The 10th principle is community wholeness. This entails transformation in totality where individuals and communities, all people including creation, experience fullness of life and overall well-being (shalom).

In the integrated alternative pastoral care and counseling model, the care begins with God image (Triune God) and God remains involved at each level of caregiving; such that even at dis-engagement towards community re-entry, the faith community continues to work with the care-seeker in sharing the fullness of life.

5.12 Chapter Conclusion

In chapter 5, the researcher's main objective was to develop a Biblical Pastoral Care and Counseling Model founded on Biblical principles. This was the fourth task (pragmatic) in accordance with Osmer' model. The main aim was to come up with principles, perspectives and guidelines that might be foundational in the formulation of a Biblical Pastoral Care and Counseling Model to be used by pastors and congregational leaders in the L.I.C and M.C.A.N's strategies of pastoral care and counseling to people involved with faith healing within belief systems. In order to come up with Biblical principles and values, the researcher did exegetical work in the select pericope of Mark 5:25-34 where the Biblical principles were established, namely God image, relationality, scriptural Truth, active participation, community and spiritual resources, pastoral competence, liberation of care-seekers, restoration and reintegration, hope building, and community wholeness.

The researcher also did a dialogical presentation of research findings from L.I.C and M.C.A.N, a literature review on faith healing within belief systems and pastoral care and counseling in the OT, NT, Pauline epistle, patristic period, the time of Jesus and the Gospel of Mark (chapters 2, 3 and 4). The researcher brough together the literature review, selected interdisciplinary models used in the research and the exegetical exercise to come up with the integrated Biblical Pastoral Care and Counseling model to be used by pastors and congregations in the L.I.C and M.C.A.N churches. The research stated the lessons learnt, made recommendations and drew conclusions to the chapter.

CHAPTER 6: CHAPTER SUMMARY, CONCLUSIONS, AND AREAS FOR FURTHER RESEARCH

6.1 Introduction

This chapter concludes the entire study on 'Pastoral care and counseling of people involved with faith healing within belief systems of L.I.C and M.C.A.N. Subsequent conclusions to chapters 1-5 are given systematically. This chapter serves to give a full summary, conclusions, and recommendations to this study and to suggest areas for further research.

6.1.1 Primary research question

The primary research question that guided this study was 'What Model of Pastoral care and counseling would show pastors and congregations how to care for people involved with faith healing and belief systems of L.I.C and M.C.A.N churches?'

6.1.2 Secondary research questions

Responses to the primary question were obtained through affiliated secondary research questions by following Osmer's tasks of practical theological research as set out below:

- What are the faith healing beliefs and healing practices of people in L.I.C and M.C.A.N? (Descriptive-Empirical Task)
- What are some of the models/methods from other disciplines used for care for and counseling people with faith healing and belief systems? (Interpretive Task)
- What Biblical perspectives on Pastoral care and Counseling are available for caring for people within the faith healing practices? (Normative Task)
- What pastoral care and counseling model would help the pastors and congregations with faith healing beliefs and healing practices in L.I.C and M.C.A.N? (Pragmatic Task)

6.2 Research Aim

This research aimed at investigating healing and care strategies to develop a pastoral care and pastoral counseling model to help people involved with faith healing within belief systems of the L.I.C and M. C. A.N churches. The purpose was to develop a Biblical Pastoral are and counseling

model to demonstrate to pastors and congregations how to care for people involved with faith healing within the belief systems of the L.I.C and M.C.A.N churches.

6.3 Research objectives

The following were the objectives of this study:

- To describe faith healing beliefs and healing practices of people among believers of the Lost Israelite church (L.I.C) (Chemororoch) and the Muungano church of All Nations (M.C.A.N) (Bukembe) (Descriptive Task)
- To evaluate some models/methods from other disciplines used for counseling people with faith healing and belief systems (Interpretive task)
- To explore the Biblical perspectives on pastoral care and counseling for people within the faith healing practices (Normative task)
- To develop a pastoral care/counseling model to show how pastors and congregations may be assisted in helping people with faith healing within beliefs and healing practices in L.I.C and M.C.A.N (Pragmatic task)

6.4 Central theological argument

The central theological argument for this study was that an integrated biblical 'Pastoral care and Pastoral counseling model can enhance care for people involved with faith healing within the belief systems of L.I.C and M.C.A.N.'

6.5 Conclusions to Chapters 1-5:

6.5.1 Chapter 1: Introduction and Problem statement

Chapter 1 addressed an introduction to the Study and problem statement and a survey of faith healing illness and wellness among the A.I.Cs in Kenya.

6.5.2 Chapter 2: Current situation of care and healing practices in L.I.C and M.C.A.N churches in Kenya (Descriptive-Empirical Task)

This chapter, which is the descriptive-empirical research task, according to Osmer's model to answer the question 'What is going on?' is the first key task in Osmer's model for practical

theological interpretation (Osmer, 2008:4). This task was applied in this chapter to help investigate pastoral care and pastoral counseling practices in the faith healing contexts within the belief systems in the contextual realities of the Lost Israelite Church (L.I.C) and *Muungano* Church of All Nations (M.C.A.N) in Chemororoch and Bukembe – Nandolia in Kenya. The study followed the mixed method research (MMR) approach in which 50 participants took part in the quantitative interview and out of the 50, 15participants took part in the qualitative interview. Participants were from both L.I.C and M.C.A.N; 25 from each church, but in total, 34 were men and 15 women. One person did not select any gender. Participants were lay members of the church and leaders who were involved in the care of people in their respective churches. Their ages ranged from 29 years to 82 years. Some were married, others widowed and some single.

6.5.3 Research Findings: Themes

The themes that were key in the research findings were:

- Caregiving and healing practices and resources
- The place of God in caregivers' search for care
- Rituals in religious care
- Community networks and attitudes
- Pastoral responses to care needs
- Challenges encountered when seeking care

Based on the themes above, participants had good knowledge of services of care, roles of leaders and practices and resources employed for healing. They also did not indicate any professional or formal counseling training for pastoral caregivers as those involved received informal education and the skills were passed down orally from those who were older. The satisfaction level was not high, as the majority indicated receiving parallel care outside their churches, or they experienced challenges even after having visited caregivers. The participants struggled with inability to afford the services due to poverty and low level of education that hindered them from getting better-paying jobs. They were concerned about strained relationships, social, spiritual and psychological counseling needs they still are confronted with. They suggested exposure and training of caregivers, material and financial support, and improved care matching the standard of the

neighbouring mission-instituted churches they visit independently. The study also established that caregivers experienced strained relationships, poverty, lack of food, basic needs for their children, transport and money for gifts needed for healing.

6.5.4 Researcher experience

During the study, the researcher experienced moments of learning unique emphases of the L.I.C and M.C.A.N churches in their healing and caregiving practices.

Informal caregiving – Caregivers had received no formal training similar to that which is stressed in formal/professional care and counseling. Availability, willingness and years of experience qualified caregivers for the important role in church.

Legalistic and authoritarian care – Pastoral caregiving leadership is based on the founders and the teams they have trained. In the two churches, strict rules are applied, and leadership is patriarchal. Care-seekers have no other options but to adhere to the rules. This limits relationship, trust building and expression of the needs. Instead, it instils fear and increases suspicion as leaders demand loyalty.

Deficient theology – The theology of the 'poor children of God' is misleading and dehumanising. Accepting to be poor, normalizing suffering, and doing nothing to improve the conditions of people dehumanizes people. People, as a rich resource can be mobilised to support one another and utilize available resources to meet their needs. The prosperity side of ministry, where leaders exploit congregations or use them to take resources for themselves while teaching congregations to be poor, is not liberative or transforming in caregiving. Poor children of God theology also brings about the imbalance in caregiving where special care is ignored. For instance, people with mental health care needs, or infertility are neglected, and this only worsens their conditions.

True image of God – Belief in the true one God, and total dependence on and trust in God leads to holistic healing. In L.I.C and M.C.A.N, belief in the founders besides the one triune and true God and his truth in scripture, stands in the way of care. Trust in and dependence on humanity idolises human beings, which makes care short-lived and bound to fail. God-human relationships are key in reformed theology, and the lack thereof makes caregivers depend on religious artefacts and animal blood instead of on God's atoning sacrifice – Jesus Christ the Messiah.

Resources for pastoral care and counseling – The researcher noticed that rich resources for care exist. However, choosing one and leaving out the other in care disadvantages care-seekers. Professional and spiritual resources come in handy in a traditional context when sensitivity is employed. Traditional resources of people, time, willingness to support, social values, norms and the wisdom of people can be utilized together with the communication skills, techniques and pastoral care functions to care for people. For this to be effective, negative factors in the context of care and in the strategies of care need to be eradicated so that they do not prevent access to care.

6.5.5 Chapter 3: Interdisciplinary models for Pastoral care and counseling of people in A.I.Cs – Interpretive Task

In this chapter, the researcher dealt with the interpretive task in accordance with Osmer's model (2008:4, 79-128). This encompassed responses to the question as to why this is going on; thus looking at the reasons leading to the situation experienced in the use of diverse models of counseling and psychotherapy in the helping professions. This helped better understand and explain the patterns and most importantly, the dynamics occurring because counsellors apply methods independently or collaborate with other teams from fields different from their own in helping people cope or address issues facing them in life. The research started off by giving a general introductory background before identifying and evaluating select 'models across disciplines' used for counseling in accordance with Osmer's interpretive task. The researcher analysed models and critiqued the relevance of the dissimilar selected models in counseling people with faith healing tendencies and belief systems in A.I.Cs. For the purpose of this study, the researcher brought into discussion the Four-Stage model of Louw, the Biblical Pastoral Care and Counseling model of Breed and the African Counseling model in order to synthesise the principles that would help form the Integrated Alternative Pastoral Model for caring for people involved with faith healing in L.I.C and M.C.A.N.

6.5.6 Chapter 4: Biblical principles and perspectives for pastoral care and healing – the Normative Task

This chapter dealt with the Normative Task according to Osmer (2008:4, 129-173). The Normative task explored the question: 'What ought to be going on?'. This dealt with addressing the question: 'What should be happening in this situation?'

The normative task makes use of sound theological concepts that interpret episodes, situations and context. Concepts to be explored in this chapter will relate to faith, illness, health, wellness and healing in pre-Biblical times; Biblical times (the Old Testament and New Testament periods as documented in Rabbinic writings, prophetic literature, in the Old Testament; New Testament approach), patristic times and views on illness and healing with specific reference to the healing ministry of Jesus, healing in the early church and in the apostolic tradition (epistles). For exegetical work, the researcher used Mark 5:25-34 and applied the historical critical method of interpretation of the select pericope. The woman who needed healing exercised faith actively while risking cultural rebuke, but trusted the source of healing power and focused on connection to Jesus. Immediately, she was liberated from her ailment and Jesus invited her to tell her story, and she was not only remembered but was made a special member – close (daughter). Sensitivity to the cultural context and final acknowledgement and affirmation of the woman who needed healing by Jesus made her feel accepted and reintegrated in the community because the flow of blood was socially and religiously segregating. The research brought the pericope into discussion with the themes: faith, healing, bringing back to life, disease and beliefs (James 5:15, Hebrew 11:16, Acts 19:11,12, Luke 5:20, Mk. 10:52, Exodus 15:26, Numbers 12:13, Ps. 103, 2 Ki. 32-35). The Biblical principles that would guide the formulation of an integrated alternative pastoral and counseling model included:

- Knowledge of God and Jesus Christ with the power to save one in need of deliverance
- Grace of God that seals health seekers' faith and belief in God and Jesus
- Faith in and belief in the healing and saving power of God
- Direct access to and communication with Jesus/God by the health-seeker
- Action/initiative of the health-seeker to intentionally act in faith
- Need for healing, and identifying source of an ultimate solution

- Encouragement, caring support, confirmation and affirmation from the caregiver
- Health-seeker's testimony – truth, acknowledgment
- Awareness of healing and knowing the healer (Christ the deliverer)
- Sharing with others to see restoration, wholeness and peace
- Cleansing, making pure for reintegration into community

6.5.7 Chapter 5: An integrated Biblical Pastoral Care and Counseling model founded on Biblical principles – A pragmatic task

Chapter 5 focused on the fourth task in practical theological interpretation – The pragmatic task. The pragmatic task sought to answer the question 'How might we respond?' In order for the study to come up with strategies or guidelines on how to respond to the pastoral care and counseling needs of people in L.I.C and M.C.A.N, the research brought into discussion a literature review, empirical findings and the exegesis of Mk. 5:25-34. The synthesis and amalgamation led to principles for integrated alternative pastoral care and counseling of people in L.I.C and M.C.A.N; thus:

1. God-Image, 2. Relationality, 3. Truth based on scripture, 4. Active participation, 5. Community and spiritual resources, 6. Pastoral competence, 7. Liberation of care-seekers, 8. Restoration and reintegration, and 9. Hope building.

God Image – Here the Triune God is a constant factor involved at every level of care. Connection to the centre ensures God's steadfast love, faith in God and total healing and wellness through God's grace.

Relationships (relationality) between God and humans is important, as God is a relational God. Similarly, relationships between human and human and between human and creation matters. Human to human relationships will ensure trust building, genuineness, acceptance, warmth, and story sharing, and listening.

Basing care on Scriptural truth from the word of God and the word incarnate counters false convictions which people have that prevent them from connecting with God, the source of healing power.

It is necessary to ensure active participation of both care-seeker and caregiver and use of resources; values, wisdom, hospitality, and spiritual resources such as sacred place, rituals from the community, including Christian symbols.

The study sees pastoral competence through professionalism, cultural sensitivity and appropriation of values and wisdom necessary for pastoral care and counseling.

Liberation from negative challenging powers or issues and setting care-seekers free is needed.

Also important is re-integration with family or the church community where aftercare is given within the social support.

Care and re-entry into the community ensures continued care within the community of faith, family and society in connection to the ultimate source of healing (God) where people continue to enjoy comprehensive wellbeing.

Building hope of life and dreams after disengagement from care and re-entry into the community is important. Care-seekers can enjoy support, and this helps them to move on with life to experience shalom with new options.

6.6 Lessons and Recommendations

We have learnt that it is good to work with all churches so that we can understand them and the factors that influence care choices they make and the care services that are available. We also learnt that the ways of Pastoral counseling giving and pastoral care in M.C.A.N and L.I.C, as is in most A.I.Cs, are different from the MICs. The L.I.C and M.C.A.N churches give advice, using the top-bottom approach whereas the MICs use formal pastoral counseling skills, techniques and models. The MICs use the western approaches that include, but are not limited to, behavioural approaches and C.P.T and psycho-analytic and Skilled Helper approaches, whereas the A.I.C's approaches lean towards the African traditional approach or incorporate both western and traditional approaches. We established that there, people expressed social, spiritual, material and psychological needs and yet there are no formal pastoral care and counseling models for people involved with faith healing within M.C.A.N and L.I.C belief systems.

With the proposed 'Integrated alternative Biblical Pastoral Care and Counseling model for people involved with faith healing within belief systems of L.I.C and M.C.A.N', leaders and congregations can care for people better. This also shows that using the biblical principles,

perspectives and values based on the exegesis of Mk. 5:25-34 and the principles from Louw's, Breed's and African Counseling models demonstrate to caregivers in L.I.C and M.C.A.N how to become competent. The context of care-seekers as was seen in the healing practices of L.I.C and M.C.A.N makes caregivers culturally sensitive. Similarly, the model empowers caregivers to see the need to have a clear God image, develop good working relationships, involve all people in care, and use spiritual resources appropriately. This further enables caregivers to do proper biblical interpretation and application, promote healing, hope and liberation, and prepare care-seekers and communities for reintegration into the community for continued care.

We recommend the use of the proposed model: Integrated Biblical Pastoral Care and Counseling Model founded on Biblical principles for 'Pastoral care and counseling of people involved with faith healing within the belief systems of L.I.C and M.C.A.N'.

6.7 Other possible areas of research

There are other possible areas of research that this study saw as being important but did not discuss due to the limited scope of study. These areas have a role in comprehensive care.

The areas are:

- the 'place of traditional rituals in pastoral care and counseling of people with AIC background,
- the 'impact of literacy on gender and choice of pastoral care and counseling options',
- the 'inter-generational gap in pastoral care and counseling options among people from AICs,
- 'Ethical leadership of pastoral caregiving during seclusion' of people involved with faith healing,
- 'Gender and pastoral care and counseling rights' and 'patriarchy and pastoral care and counseling' in A.I.Cs', and
- The place of colonialism and patriarchy in the shaping of pastoral care and counseling among people with an AIC background.'
- Gender, Sexuality, patriarchy, and faith healing.

- These were areas beyond the scope of this study but are worth investigating as they are linked to care options in L.I.C and M.C.A.N.

6.8 Conclusion

This Chapter is a conclusion to the study, 'Pastoral care and counseling to people involved with faith healing within belief systems of L.I.C and M.C.A.N. The research gave the summaries of chapters 1 to 5; thus Chapter 1: Introduction, problem and background to the study; Chapter 2: Current situation of care and healing practices in L.I.C and M.C.A.N churches in Kenya; Chapter 3: Interdisciplinary models for Pastoral care and Pastoral counseling of people in AICs; Chapter 4: Biblical principles and perspectives for pastoral care and healing; and Chapter 5: A proposed Biblical Pastoral Care and Counseling model founded on Biblical principles.

The researcher proposed an integrated Biblical Pastoral Care and Counseling model founded on Biblical principles for effective 'Pastoral care and counseling of people involved with faith healing within the belief systems of L.I.C and M.C.A.N'. Lessons were learnt on leadership of care.

The study opened other possible areas of research, such as: The 'place of traditional rituals in pastoral care and counseling of people with an AIC background, the impact of literacy on gender and choice of pastoral care and counseling options', the 'inter-generational gap in pastoral care and counseling options among people from AICs,' 'ethical leadership of pastoral caregiving during seclusion' of people involved with faith healing, 'Gender and pastoral care and counseling rights', 'patriarchy and pastoral care and counseling in AICs and the place of colonialism and patriarchy in the shaping of pastoral care and counseling among people with an AIC background.'

ANNEXURE 1: QUESTIONNAIRE

QUESTIONAIRE

Pastoral care and counseling to people involved with faith healing within belief systems of M.C.A.N and L.I .C

Welcome, and thank you for accepting to participate in this study. Choose the option most relevant to you and please answer all other questions honestly.

This study seeks to get your honest views on the care of members needing pastoral care in your congregation. Views you give will inform formulation of sound pastoral care and pastoral counseling model to help people involved with faith healing within belief systems that need of care. Participation is voluntary and feel free to opt out if you feel uncomfortable.

PART 1: Participant biographical data

Venue_ Chemororoch / Bukembe _____

Age:_____years.

Gender: Male/ Female_____

Marital Status: Married /Unmarried_____

Education: Primary Secondary/ Diploma / Degree_____

Position in congregation: Member / Leader_____

Part: 2 Questions

1. How well do you know the ways used by your church to talk to and support people needing pastoral care and counseling? Please indicate your choice with an X
   A) Very well [ ]
   B) Slightly well [ ]
   C) Not well [ ]
   If your answer is A, B or C, please clarify your answer.

   _____

   _____

   _____

_____

_____

_____

2. If your answer is A) very well or B) slightly well in the above, please tell us briefly about the key ways used to care for people in your church.

_____

_____

_____

_____

_____

3. How long ago were you supported and talked to by a caregiver in your church when having a pastoral problem? Please indicate your choice with an x

A) 6-12 months [ ]

B) 1-4 years [ ]

C) 5-10 years [ ]

D) 11-40 years

If your answer is A, B, C, or D, please clarify your answer.

_____

_____

_____

_____

_____

4. How does your church respond to the needs of people in need of pastoral care in their lives? Please indicate your choice with an X on all applicable.

A) Visitation [ ]

B) prayer [ ]

C) Anointing [ ]

D) Others. Please specify

_____

_____

_____

_____

_____

_____

_____

_____

5. What beliefs, faith teachings and religious practices influence pastoral care in your search for healing in your church?

_____

_____

_____

_____

_____

_____

6. What specific religious activities found in your church help you to find healing when you are unwell or need of pastoral care? Mark your answer with x.

a) Taking gift Offerings

e) Anointing with oil

b) Making Sacrificing

f) Prostrating

d) Praying

g) others Specify)

_____

_____

_____

_____

_____

_____

_____

7. What is the place of God in your search for healing? Please indicate your choice with an X on most suitable.

A) Healer [ ]
B) Strength [ ]
C) Comforter [ ]
D) Others, please clarify your answer [ ]

_____

_____

_____

_____

_____

_____

_____

_____

8. Does your church have people charged with responsibilities of listening and responding to the pastoral care & counseling needs? Please tell me who they are by indicating your choice with an X.
   A) Yes, Pastors only [ ]
   B) Yes, pastors and overseers only [ ]
   C) Yes, pastors, overseer and elders [ ]
   D) Yes, pastors and congregation.
   If your answer is D above, please clarify. [ ]

_____

_____

_____

_____

9. What forms of counseling do those charged with listening ad responding to pastoral care and pastoral counseling needs use in care?

   a) Individual
   b) Group
   c) Family
   d) Couple/marriage
   e) Others, clarify

_____

_____

_____

_____

_____

10. What special role if any do the religious people charged with listening and responding to pastoral care needs of people in the congregations play?
Advise people[ ] pray [ ] asses needs [ ] determine gift [ ]

Forgive wrongs[ ]sacrifice [ ] read bible [ ] prescribe care [ ]

Lay hands [ ] touch the sick[ ] refer to hospital [ ] discipline [ ]

Exorcise [ ] wash the sick [ ] bless [ ]others specify [ ]

_____

_____

_____

_____

_____

_____

11. What do you as a member of your church in need of pastoral care do, so that you can get healing? Tick which applies to you.

Send offering [ ] have faith[ ] Tell Nabii at home [ ]visit high priest [ ]

Talk to leader [ ] accept care[ ] lie down for healing [ ] follow teachings[ ]

Visit healer [ ] keep quiet [ ] share issues with others [ ] ask counsellors [ ]

Visit other pastors[ ] visit clinic[ ] pray and take medicine [ ] ask diviners [ ] Obey all rules [ ] take herbs [ ]only use herbs & touch [ ] touch sacrifice [ ] Faith in Jehovah [ ] take gift [ ] use herbs, prayer& medicine[ ] others, clarify [ ]

_____

_____

_____

_____

_____

_____

12. What helping skills and knowledge do caregivers (religious leaders) in your church have that helps them care for people in need of counseling support?

Many years [ ] prescribe [ ] give instructions [ ] sing [ ]

Assessment]] touching [ ] divination [ ] present offerings [ ]

Advise [ ] marching [ ] foresee [ ]identify needs [ ]

Counsel [ ] interpret bible[ ]counsel [ ] share solution [ ]

Drum beating[ ] lay hands [ ] pray [ ]others, please specify [ ]

_____

_____

_____

_____

_____

13. What religious (spiritual) resources help the caregivers in meeting the needs of people in need of care and healing in your church? Please indicate your choice with an X on all applicable.
    A) Bible [ ]
    B) Songs [ ]
    C) Holy oil [ ]
    D) Others, please specify [ ]

_____

_____

_____

_____

_____

_____

14. What teachings and doctrinal tenets influence strategies of care and counseling in your church?
    a) Faith in Jehovah [ ] Altar [ ] Jehovah heals, bless & forgives [ ]
    b) Respect Sabbath [ ] offerings [ ] prophecy [ ] Angels & healers [ ]
    c) Faith in Nabii [ ]shrine [ ] curses [ ] witchcraft [ ]
    d) Remain Pure [ ] discipline [ ] new bible [ ] flags & sword [ ]
    e) Obey commandments [ ] use herbs [ ] anointing [ ] law of Moses [ ]
    f) Give offerings for needs [ ] follow rules[ ] keep secrets[ ]others, specify [ ]

_____

_____

_____

15. What challenges do you face as you seek for care and healing in your church?
    a. No transport [ ] fall sick after visits
    b. Hospital heals [ ] no jobs and money[ ] diviners help [ ]
    c. Stigma & ridicule [ ] church is far [ ] other pastors help[ ]
    d. Cannot buy gifts [ ] keep silent[ ]not respected[ ] delayed healing[]
    e. No support [ ] lack food [ ] treated as different[ ] people shun us[ ]

    _____

    _____

    _____

    _____

    _____

    _____

16. What else needs to be done to improve care and counseling support needed for healing in your church?
    a) learn from other churches how they care and counsel
    b) train pastors and leaders on pastoral care and pastoral counseling
    c) create awareness of use of spiritual resources in care and counseling
    d) Others. Please clarify_____

    _____

17. What alternative care options do you have available for you and members of your congregation? Please indicate your choice with an x
    A) Traditional herbal healers [ ]
    B) Witchdoctors [ ]
    C) Hospitals [ ]
    D) Others, please specify [ ]

    _____

    _____

    _____

    _____

    _____

18. What other helpful information can you give to this research?

    _____

    _____

    _____

    _____

    _____

Thank you for your time and response.

ANNEXURE 2: GUIDED INTERVIEW QUESTIONS

Guided Interview Questions

Pastoral care and counseling to people involved with faith healing within beliefs systems of M.C.A.N and L.I.C

Welcome, and thank you for accepting to participate in this interview.

The focus of this interview guide is pastoral care and pastoral counseling practices to people involved with faith healing and belief systems in your congregation. This interview seeks to get views that will inform the formulation of a sound model for pastoral care and pastoral counseling to help people involved with faith healing within belief systems of L.I.C and M.C.A.N to effectively meet the care needs of members.

Part 1: Demographic Data

Respondent_____Date_____

Venue_____Time_____Religion_____

Age_____Gender_____Status_____

Education_____Income_____

Position_____

Part 2. Semi-structure interview-Guided Interview Questions

1. What is your honest view of care of challenged people and healing in your church?
2. Can you explain how care and healing religious rituals are performed in your in your church organization
3. How do you see these care and healing rituals assist in meeting the spiritual needs in people's struggles?
4. Who are key spiritual caregivers/counsellors who support people when they are disturbed?
5. What doctrinal/constitutional values and teachings affect pastoral care, pastoral counseling, and healing in your church?
6. Is there any other better way you think people could be assisted to address counseling challenges?
7. I wish to know, in your opinion where people go to be counselled when they are challenged in your church?

8. What counseling knowledge and skills do people charged with listening and responding to care needs in your congregations have?
9. What forms of counseling do those charged with listening ad responding to pastoral care and pastoral counseling needs use in care?
10. What needs to be added to make pastoral care and pastoral counseling effective in meeting challenges people in your church face
11. What pastoral counseling options do people with care needs have in your church?
12. I wish to know from you who God is, and what his place is in your life struggles and healing?
13. What spiritual struggles need more pastoral care and pastoral counseling in your church?
14. What spiritual resources do you find available and useful pastoral care and pastoral counseling healing in your church?
15. What challenges are faced during pastoral care and pastoral counseling in your church?
16. What other contributions can you offer to this study?

Thank you very much for your cooperation and contribution to this study, feel free to communicate through the email address or the phone number given should you have any other information that will assist with this study.

ANNEXURE 3: MUUNGANO CHURCH OF ALL NATIONS AUTHORIZATION LETTER

Muungano Church of All Nations

P.O Box 285

Bungoma.

Date: 9-2019

TO : WHOM IT MAY CONCERN

To: Rev. Edith K.Chemorion

RE: PERMISSION TO CONDUCT ACADEMIC RESEARCH IN MUUNGANO CHURCH OF ALL NATIONS.

This is to confirm that I have granted permission to Rev. Edith Khakasa Chemorion who is doing PHD research at NWU on the topic - faith healing and belief systems among African Instituted churches- An integrated approach in pastoral care strategies to do research among the leaders and members of the Muungano Church of all Nations at Nandolia, Bukembe in Bungoma County.

Thank you

Nabii Yohana

Sign:.....

ANNEXURE 4: L.I.C CHURCH AUTHORIZATION LETTER

The Lost Israelites of Kenya Church

Chemororoch Headquarters

P.O Box 184

MATUNDA

10th January, 2019

TO WHOM IT MAY CONCERN

To: Rev. Edith K.Chemorion

RE: PERMISSION TO CONDUCT ACADEMIC RESEARCH IN THE LOST ISRAELITES OF KENYA-CHEMOROROCH HEADQUARTERS

This is to confirm that we, leaders of Lost Israelites of Kenya Church of Jehovah Wanyonyi have granted permission to Rev. Edith Khakasa Chemorion who is doing PHD research at NWU on the topic - faith healing and belief systems among African Instituted churches- An integrated approach in pastoral care strategies to do research among the leaders and members of the congregation at Chemororoch headquarters anytime.

Thank you

On behalf of the Lost Israelite of Kenya-Chemororoch headquarters

Secretary

William Misiko Waswa

Sign:----------

High Priest

Dominic Makokha Eliab

Sign:----------

ANNEXURE 5: INDEMNITY

INDEMNITY

I, the undersigned

Edith Khakasa Chemorion_____

Identity number: 28453875_____,

hereby indemnify the North-West University ('NWU') and/or any of its office-bearers and staff (temporary or permanent) against any liability in respect of personal losses and/or damages suffered by me or any other person arising from or resulting as a consequence of my participation in the research entitled Faith Healing and Belief Systems Among African Instituted Churches – An Integrated Approach in Pastoral Care Strategies _ (the 'Research'), and hereby hold harmless the NWU against above-mentioned liability.

I confirm that I voluntarily consent to participate in the Research, and that I was in no way forced or coerced by the NWU to participate in the Research, and that the waiver and release shall apply to any claims that may arise during and/or after the Research.

I declare that I am aware of the risks involved in the Research, as explained to me, and of the implications of this waiver and release, and agree that this document shall also be binding upon my executor, curator or other assigns.

Signature _____

Date _____

ANNEXURE 6: INFORMED CONSENT

INFORMED CONSENT

HREC Stamp

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR……

TITLE OF THE RESEARCH STUDY**: 'Pastoral care and counseling to people involved with faith healing within belief systems of M.C.A.N AND L.I.C'**

ETHICS REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: EDITH KHAKASA CHEMORION

ADDRESS: Die Karoo, 15, Borcherd Street, Potchefstroom, SA.

CONTACT NUMBER: +27748183358, +254724253764

You are being invited to take part in a research study that forms part of my PhD in Pastoral Studies. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is entirely voluntary, and you are free to say no to participate. If you say no, this will

not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU.....) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

The aspiration to see that a holistic, competent and Biblically sound model that will show pastors and congregations to care for the needs of people involved with faith healing withing belief systems of L.I.C and M.C.A.N. The aim of this research was to investigate healing and care strategies in order to develop a pastoral care and pastoral counseling model to help people involved with faith healing within belief systems of L.I.C and M. C. A.N.

.

Why have you been invited to participate?

- *You have been invited to be part of this research because you are a valuable member of the L.I.C /M.C.A.N congregation, and or part of the leadership. Your views shall contribute to an improved model for care of people with disturbances/needs in L.I.C and MCAN.*
- *You also fit the research because you are part of the care giving team in the L.I.C/M.C.A.N churches.*

What will be expected of you?

- *To be involved in this research at your own will and respond to the research questionnaire and interviews without coercion. You will be free to state your views without undue influence*

Will you gain anything from taking part in this research?

- *The direct gains for you if you take part in this study will be that your involvement will contribute towards developing an integrated pastoral care model that will be used by pastors and church leaders in L.I.C and M.C.A.N*
- *The other indirect gains of the study are that the LIC and M.C.A.N churches will use the outcome of this study to enhance the care of needs of members of congregations.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study are not there as information gathered in this research will be kept confidential and that names of all participants will not be disclosed. Gains for you in joining this study outweigh the risks.*

How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by the principal investigator Edith Chemorion and Research supervisor Prof. Gert Breed. Privacy of all participants will be respected.*

What will happen with the findings or samples?

- *Results of study will be kept confidential under lock in researcher's office and accessed only by the principal investigator and research supervisor. After data has been documented, information on forms and recorders will be deleted.*

How will you know about the results of this research?

- The findings of this study will only be used for Academic purposes in developing Doctoral Thesis for my (PhD) studies at North-West University-Potchefstroom Campus

Will you be paid to take part in this study and are there any costs for you?

No. you will not be paid to take part in the study, thus there will be costs involved for you if you do take part in this study.

Is there anything else that you should know or do?

- Feel free to Contact Edith Chemorion on +27 +254 724 253 764 or Email: at ekchemorion@gmail.com if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will also receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I .....agree to take part in the research study titled:…….

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.

- I understand that taking part in this study is voluntary and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 20....

....
Signature of participant Signature of witness

Declaration by person obtaining consent

I *(name)* .....declare that:

- I explained the information in this document to ……..
- I am satisfied that he/she adequately understands all aspects of the research, as described above
- I encouraged him/her to ask questions and took adequate time to answer them
- The informed consent was obtained by an independent person..
- I did/did not use an interpreter

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 20....

....
Signature of person obtaining consent Signature of witness

Declaration by researcher

I *(name)* .....declare that:

- I explained the information in this document to ……..
- I am satisfied that he/she adequately understands all aspects of the research, as described above
- I encouraged him/her to ask questions and took adequate time to answer them
- I did/did not use an interpreter

Signed at (*place*) .....….....…….. on (*date*) ……...…….. 20....

....

Signature of researcher Signature of witness

ANNEXURE 7: CONFIDENTIALITY

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

entered between:

I, the undersigned

Prof / Dr / Mr / Ms___EDITH CHEMORION_____

Identity Number:____28453875_____

Address: Die Karoo, 15, Borcherd Street, Potchefstroom, SA._____

hereby undertake in favour of NORTH-WEST UNIVERSITY, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the 'NWU')

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 'Confidential Information' shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 ‘Commencement Date’ means the date of signature of this undertaking by me.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this __10th October 2018____

Witnesses:

1 .....

2 ....
(*Signatures of witnesses*) (*Signature*)

(*date*) ……...…….. 20....

....
Signature of participant Signature of witness

Declaration by person obtaining consent

I *(name)* .....declare that:

- I explained the information in this document to ……..
- I am satisfied that he/she adequately understands all aspects of the research, as described above
- I encouraged him/her to ask questions and took adequate time to answer them
- The informed consent was obtained by an independent person..
- I did/did not use an interpreter

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 20....

....
Signature of person obtaining consent Signature of witness

Declaration by researcher

I *(name)* .....declare that:

- I explained the information in this document to …….
- I am satisfied that he/she adequately understands all aspects of the research, as described above
- I encouraged him/her to ask questions and took adequate time to answer them
- I did/did not use an interpreter

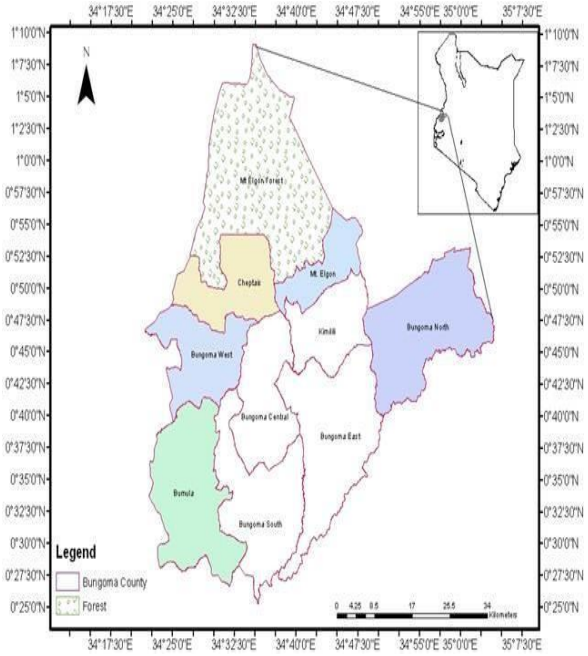
Signed at (*place*) .....…..…….. on (*date*) ……...…….. 20....

....
Signature of researcher Signature of witness

ANNEXURE 8: BUNGOMA COUNTY- ADAPTED FROM SCIENCE PUBLISHING GROUP JOURNAL, 2020.

The map of Kenya showing counties adapted at AMAZON.com

The map of Uasin Gishu County-google maps, 2020.




ANNEXURE 9: THE SWORD AND THE ALTAR (L.I.C)

ANNEXURE 10: ETHICS APPROVAL LETTER OF STUDY

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Fax: 018 299-4910
Web: http://www.nwu.ac.za

Senate Committee for Research Ethics
Tel: 018 299-4849
Email: nkosinathi.machine@nwu.ac.za

29 March 2021

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the **Theology Research Ethics Committee (TREC)** on 29/03/2021, the Theology Research Ethics Committee hereby **approves** your study as indicated below. This implies that the North-West University Senate Committee for Research Ethics (NWU-SERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Pastoral care and Pastoral counselling to people involved with faith healing within belief systems of M.C.A.N and L.I.C

Study Leader/Supervisor (Principal Investigator)/Researcher: Prof Gert Breed

Student: Chemorion, EK = #28453875

Ethics number:

N	W	U	-	0	0	7	5	9	-	2	1	-	A	7
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single Study

Commencement date: **2021/04/01** **Risk Category:** **Minimal risk**

Expiry date: 2022/03/31

Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

General conditions:

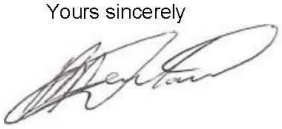
While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The study leader/supervisor (principle investigator)/researcher must report in the prescribed format to the TREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*

- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the TREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility, the NWU-SCRE and TREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected;*
    - *it becomes apparent that any relevant information was withheld from the TREC or that information has been false or misrepresented;*
    - *submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *TREC can be contacted for further information or any report templates via Rudy.Denton@nwu.ac.za.*

The TREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the TREC or the NWU-SCRE for any further enquiries or requests for assistance.

Yours sincerely



Dr Rudy Denton
Chairperson NWU Theology Research Ethics Committee

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8 November 2018

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ANNEXURE 11: DECLARATION OF LANGUAGE EDITOR

12 July 2021

I **Ms Cecilia van der Walt** hereby declare that I took care of the **editing** of the **thesis** of **Ms Edith Khakasa Chemorion** titled ***PASTORAL CARE AND COUNSELING OF PEOPLE INVOLVED WITH FAITH HEALING WITHIN BELIEF SYSTEMS OF M.C.A.N AND L.I.C.***

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