Pastoral Care for Mental Health In-patients:

An area of concern for Christian Churches in the Southampton Area, UK

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Abstract

The challenge of meeting the spiritual needs of psychiatric patients is a pressing concern whilst western societies are increasingly characterised by secularism and the decline of organised religion. Drawing on the findings about the current level of pastoral care provision in churches as well as the biblical perspective of pastoral care, the study introduces and discusses a framework for pastoral care provision for mental health patients by Christian churches. Structured interviews of church leaders and a survey of Christian health workers were conducted to examine the present provision of pastoral care for mental health patients in Southampton. The framework can serve as a guideline to improve the efficacy and quality of pastoral care provision for mental health patients. The findings indicate that there is minimal provision made by churches for pastoral care for mental health patients. This study sought to bridge this gap by focusing on pastoral care provision for mental health patients in Southampton. Finally, the study offers recommendations to improve pastoral care provision.

Key Words: Spirituality, Religion, Pastoral Care.

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Glossary

- **Spirituality**: The ways in which a person habitually conducts his or her life in relationship to the question of transcendence (Sulmasy, 2009:1638).
- **Inpatients**: The concept of "inpatient" here refers to those from Southampton church communities who find themselves in hospital during the acute phases of their mental illness, but who otherwise live their lives in the community.
- **Clergy**: According to the English Oxford Living dictionary (McCulloch, 2013:189) "the clergy is the body of all people ordained for religious duties, especially in the Christian Church".
- **Mental illness**: There are many different mental disorders, with different presentations. These disorders are normally identified by a number of symptoms which include abnormal thoughts, perceptions, emotions, behaviour and relationships with others. Mental disorders include depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders, including autism (Udo & Grilo, 2018:1).
- **Pastoral care**: The word is derived from the Latin root *pascere* (to feed) and articulated by the powerful metaphor of the Good Shepherd; pastoral care describes the spiritually and morally sustaining concern of the pastor for his or her flock (Dooley, 1980:21).

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CHAPTER 1: INTRODUCTION

1.1 Background

This study was brought about by an experience with a member of the study author's congregation who has a mental health condition but is literally treated as a criminal and at all cost avoided by members of the congregation. There were no structured safeguarding plans in place to help him by the church. The member was not involved in church programmes and was not catered for but was watched with disdain. Church traditions and practices appear to be more important to Christian Churches than providing pastoral care.

Whilst Western societies are increasingly characterised by secularism and the decline of organised religion, research suggests that religion and spirituality nonetheless play important roles in the lives of a large number of medical and psychiatric patients (Bari, 2011:1; Blumenthal *et al*., 2007:504; Hartz, 2005:40). Research further demonstrates that people who describe themselves as "spiritual" have better chances of staying mentally healthy or of recovering if they become unwell (Tidyman & Seymour, 2004:18). Furthermore, there is a growing demand from service users and service providers for healthcare that treats the whole person. A further study also acknowledges there are many facets of the person that influence both physical and mental wellbeing. Commentators within related fields, such as Willows and Swinton (2000:81), Coyte, Gilbert and Nicholls, (2007:334), Seybold and Hill (2001:23), Cox, Campbell and Fulford (2007:22) and Lawler-Row and Elliott (2009:47), have all grappled with the role of spirituality and religion in the recovery of psychiatric patients for a number of years (Grainger, 1979:44).

1.2 Problem Statement

The challenge of meeting the spiritual needs of psychiatric patients is a pressing concern whilst western societies are increasingly characterised by secularism and the decline of organised religion. Mental and emotional disorders are regarded as an extreme handicap for those who have to live through them, a financial burden for a society that maintains those who cannot care for themselves, and a source of concern for families who try to remain in loving relationships, even while experiencing hardship.

There are many works that highlight the need to address this problem and demonstrate the importance of spiritual care for people with mental health problems within the Christian Church, for example, Swinton (2001); Pattison (1994) and Grainger (1993). However, too often churches fail to offer adequate care to individuals with often complex needs (Carson, 2008: xxvi-xxiv; Granger, 1979:57-79) to highlight the important role played by chaplains as part of a multi-disciplinary team in hospitals in aiding the recovery of patients with mental health conditions. These publications are examples of general overviews of this important subject, but what is lacking are specific studies of pastoral care provision by Christian Churches.

The impact of mental illness on the individual and the society is well-documented (Secker, 2009:6). According to the Mosby Medical Dictionary (2009), inpatient or acute care is provided in hospital by a team of staff where patients are treated briefly for severe but short episodes of illness. It has been reported that some Christians with mental health illness do not get support from their church members once they are in the acute phase of their illness and are admitted to hospitals (Nauert, 2011:1).

Having a psychological or psychiatric illness can be devastating for individuals, not only because of the nature of the illness itself, but also because of the very process of coming into contact with psychiatric hospitals. Individuals suffering with psychiatric disorders are often isolated from their communities because of the prevalent stigma attached to the "Mental Health" domain (Griffiths *et al*., 2014:169).

A survey conducted by Rethink in 2008 reveals that "out of 3,000 people affected by mental health conditions across England, 87% said that they had direct personal experience of stigma and discrimination due to their illness" (Corry, 2008:8). Despite growing campaigns to raise awareness and understanding of mental health conditions, this stigma still exists and it is responsible in some cases for the active rejection of people with psychiatric conditions from within their own social setting (Thornicroft *et al*., 2008:2). Lack of understanding can lead individuals to feel that their association with a psychiatric hospital may be detrimental to relationships with family, friends and communities around them. This brings more stress into their lives and, as a result, aggravates their illnesses (Sweeney *et al*., 2015:1083).

Spiritual support, or pastoral care, can become an essential tool in the treatment plan of individuals, and is readily available for them in their communities, their churches, or even the psychiatric hospitals (Burgess *et al*., 2008:902; Corry, 2008:8; Willows & Swinton, 2000:86). Willows and Swinton (2000:19) explain that the quality of experiences that psychiatric patients require goes beyond just the health care that they are given, but also includes the need to strive for inspiration, reverence, purpose and a meaning in life. People naturally ask for answers in times of difficulty and this is the time when most mental health patients require spiritual support. These views help

minimise stigma and separation that so persistently follow those who suffer mental or emotional disorder.

Wood *et al*. (2011) examined Christian clergy involvement with people with mental health problems. The study found that the clergy are largely being left as front-line workers without any training. The study presents data on the prevalence and nature of their involvement with mental health issues within their communities, their attitudes towards mental health and mental health services and looks at the referral practices. However, it lacks focus on pastoral care in the local community.

Foskett (2001) explored the complex history of pastoral care and its roots in religious and theological theory and practice and influence of human sciences. He also identified the importance of pastoral care for people with mental health problems and offered some examples of good practice which recognise and use the different perspectives of users, mental health and religious professionals. However, this study also covers the wider perspective, but not a detailed study of pastoral care provision in a local context.

Stansbury *et al.* (2011) explored the perspectives of African American clergy on gerontological mental health and pastoral care to elderly congregants. Interviews were conducted with 18 African American clergy in Kentucky. Data analysis revealed two salient themes: holistic health and holistic pastoral care. These findings have implications for training and continuing education of clergy, in addition to the need for increased collaboration among social workers and clergy. Although this study was done in the United States of America, it is applicable to pastoral care provision in the United Kingdom (UK). This however, may require further studies in the local context.

Leavey (2005) examined the convictions of clergy from the Christian, Jewish and Muslim faiths towards people with mental health problems and discovered that for the majority of these individuals, their pastoral support for individuals was compatible with psychiatric intervention. However, many lacked formal training in caring for the mentally ill and found dealing with it often perplexing and challenging. Leavey's work covers the wider picture, but also lacks detailed study of pastoral care provision in a local community.

Uwannah (2015) focussed her research on the experience of specifically Pentecostal Christians with mental health conditions and outlined the response of three particular congregations in her research. In particular, she drew attention to the experience of the church members as recipients of support from their respective congregations. The aim of the study was to aid Counselling Psychologists in the process of efficient liaison work between churches and mental health agencies. The study had, therefore, a broader purpose than the provision of pastoral care for members within church contexts.

Wonders (2011) produced an excellent overview study of Christian pastoral care provision for people experiencing mental illness within a select sample of mainstream Christian congregations in South Yorkshire. However, more studies are required to see if a similar or contrasting picture of pastoral care provision emerges in other communities in the UK.

As a result, it is clear that there is room for many more local studies on the provision of pastoral care for people with mental health problems in the UK. This study contributes towards filling this gap in our knowledge.

1.3 Defining Pastoral Care

Alastair Campbell (1987:188) defines pastoral care as a care that is "concerned with the well-being of individuals and of communities" (Campbell, 1987:188). Crossley (1992:12) says that pastoral care is the sole prerogative of the pastor. The care of a lost or dying soul is not a side interest in the pastor's life and work. It is his life's work or in other words the primary responsibility of the pastor. It is exercised though preaching, teaching, the supervision of public worship, the leadership of the church and through private pastoral counselling. In the context of this study, pastoral care does not preclude the establishing of a pastoral team to provide pastoral care under the pastor's leadership.

On the other hand, Crossley (1992:14) defines counselling as the relationship between one human being and another in which help is given towards solving problems of living such as anxiety, grief, guilt, resentment, uncontrolled desires and appetites, selfishness, feelings of insecurity or worthlessness, indiscipline and destructive patterns of behaviour.

Pastoral care is the soul and breath of the pastor and it is on this basis that a pastor's role and activities are defined. Pastoral counselling is usually used in private conversations where the pastor uses words of comfort, support, challenge or at times gives advice to individuals. Jesus referred to himself as the Good Shepherd (John 10:11). The author of Hebrews called Him the Great Shepherd (Hebrews 13:20). In Luke 10, it is also evident that Jesus recruited the Twelve as his first line of help, then seventy-two disciples who were to assist him bring the dying world back to the Kingdom of God.

1.4 Research Questions

From a pastoral care perspective, how can churches in Southampton meet the spiritual needs of mental health patients? The questions that naturally arise from this are:

- To what extent at present is provision made by Southampton churches for the pastoral care of mental health patients?
- What is the difference between religion and spirituality and how does this impact the provision of pastoral care for mental health patients?
- What scriptural perspectives may be found regarding the pastoral support of the mentally ill and how these can be applied to present day pastoral care?
- How can a practical way be devised to improve the efficacy and quality of pastoral care provision in mental health?

1.5 Aim

The aim of this study is: **to investigate how churches in Southampton can meet the spiritual needs of mental health patients from a pastoral care perspective**.

To meet the aim of the study, the following objectives were formulated:

1. To examine the present provision of pastoral care for mental health patients.
2. To assess the difference between religion and spirituality and its impact on provision of pastoral care for mental health patients.
3. To explore biblical approaches to pastoral support of the mentally ill and their applicability to present day pastoral care.
4. To propose a framework to improve the efficacy and quality of pastoral care provision in mental health.

1.6 Central Theoretical Argument

The central argument of this research is that psychiatric patients need spiritual attention to maximise their chances for improvement or recovery, for which Christian churches in the UK need to make effective provision.

1.7 Research Methodology

Due to limited resources (time and financial), the study limited itself to the City of Southampton. However, the outcomes of the study are applicable to other areas of the United Kingdom due to their cultural and demographic similarities. Southampton was selected due to the author's familiarity with and work experience in the area. Throughout the study, the term church is used in the context of Christian churches only. The study relied on both primary and secondary data.

1.7.1 Theoretical Foundation and Secondary Data

The theoretical foundation of this study's objectives is based on the work of Richard Osmer (2008). This method is primarily a preferred method by the University and also due to the extensive and systematic approach to practical theology and pastoral leadership. Osmer creates a fourfold vision of the tasks of practical theology. This can be compared to a medical approach where an initial assessment is made, followed by diagnosis, treatment-plan and treatment. Osmer uses a similar approach in order to understand the congregation and their needs. The systematic approach points to a need to understand and diagnose the environment of congregations. Thus, Osmer's methodology was considered appropriate and best for the study.

Osmer (2008) draws attention to the four approaches to pastoral care as shown in Table 1.1.

Table 1.1: Approaches to pastoral care paradigm.

Task	Function
Descriptive-empirical	"What is going on?"
Interpretive	"Why is it going on?"
Normative	"What ought to be going on?"
Pragmatic	"How might we respond?"

Osmer (2008) concentrates on the pastor as interpretive guide, a stance that has obvious relevance to this research. Osmer (2008) draws attention to the concept of the "hermeneutical circle" (or better still, the "hermeneutical spiral") to clarify the relationship between the Descriptive, Interpretive, Normative and Strategic pastoral tasks. This research paradigm was used in carrying out the following:

- A literature search relevant to the provision of pastoral care by churches in Southampton to inpatients in psychiatric hospitals
- Examination of the differences between the terms "spirituality" and "religion"
- Exegesis of the themes of pastoral care and illness developed from the Old Testament, and then compared with the concept of mental illness in the New Testament, with examples in Mark 5:1-20, Luke 8:26-40 and Matthew 8:28-34.
- A qualitative research approach similar to those mentioned in Murray and Chamberlain (1999) was adopted in order to understand the feelings of interviewees. This was achieved by the use of semi-structured questionnaires and discussion groups that aim to examine the presenting problems.

- Proposed solutions to the problems, drawing conclusions based on analysis of findings and developing constructive recommendations for local churches.

Census data for Southampton was sourced from online archives of the Southampton City Council (Southampton City Council, 2011).

1.8 Primary Data Collection

Primary data was collected by carrying out a number of structured interviews.

Ethical clearance was implemented as it forms a crucial part in my research project for the very obvious reasons as vulnerable people were involved. All necessary caution required in order to ensure the research was conducted in a responsible and ethically accountable way, in line with the agreed standards of North West University, South Africa. It was also important to minimise the risk of harm to all individuals involved in the process and sought to ensure that the research lead to beneficial outcomes. In this case to highlight the need for improved pastoral support from the churches in the Southampton area for members with mental health problems

An ethical clearance committee were involved in looking at my research aims and methodologies. Research questions were produced and made available to the committee in order to make sure that the research was conducted in a way that protects the dignity, rights and safety of the participants, especially the patients with psychiatric disorders. The questionnaire was found to be ethically sound and was able to solicit information required to answer the research question.

Patients were removed from the ward environment to the hospital sanctuary with an allocated member of staff who was seated nearby in order for interviewees to feel

comfortable and secure. Interviews were conducted on a one-on-one basis in order to avoid any pressure that might have ensued from discussions in a larger group. To help prepare them for our conversations and to avoid any surprises patients were given all necessary information prior to the interview and were informed and assured of strict confidentiality. They were also informed of their right to terminate the interview if and when they felt uncomfortable. Outpatients were seen in their own homes, but hospital staff and the members of local churches were all interviewed at the local psychiatric hospital. Please see the certificate of ethical clearance in Annexure D.

Structured interviews consist of administering structured questionnaires enabling interviewers to ask questions in a standardised manner. It enables the researcher to examine the level of understanding a respondent has about a specific topic in a lot more depth than with other data collection techniques. Structured interviews are the most widely used format for qualitative research and can occur either with an individual or in groups one-off or repeated several times over a period to track developments. The interviewer is in a good position to judge the quality of the responses, clarify misunderstood questions and to encourage the respondent to be full in their responses (DiCicco-Bloom & Crabtree, 2006, Gill *et al.*, 2008, Walliman, 2017, Whiting, 2008).

The questions used in the interviews for this study are presented in the appendices. The questions used were carefully formulated in accordance with the study objectives. The questionnaire in Appendix C was used in a mini-survey of healthcare workers. The respective data collection exercises are further described in the following sub-sections.

1.8.1 Inpatients

On 11th September 2017, an interview was conducted on Trinity Ward (female) in Antelope House, the psychiatric hospital in Southampton. Trinity Ward is a twenty-five-

bed ward; however, out of the twenty-five individuals approached, only five were willing to talk and agree to be interviewed. The five only agreed on the basis that the interviews took place in the multifaith room, which was outside of the ward. The interviews were conducted on an individual basis and in their own comfort. A member of staff was asked to sit outside the door for two of the respondents as part of the hospital security measures. Both were remanded under section two of the Mental Health Act, 1983.

1.8.2 Outpatients

The Community Mental Health Team (CMHT) in Southampton was contacted to request permission to interview their Christian patients. Participation in the interviews was voluntarily. CHMT availed the contact details of the patients that were willing to take part in the interviews. Subsequently, contact was made with the patients to arrange home visits where the interviews were conducted. In total, 6 mental health outpatients were interviewed between the 16th and 17th October 2017.

1.8.3 Church Leaders

An online search for Christian churches in Southampton was conducted and a list drawn up of their website addresses. The sites were visited and the churches' email addresses were collated. Invitation to participate in the study were sent out via email to the churches. Several of them replied, stating their willingness to participate. Interviews were subsequently arranged via telephone calls.

Seven church leaders were interviewed on 9th and 13th January 2018, some at the Psychiatric Hospital in Southampton and others at Moorgreen Hospital. In each case, an

interview room was arranged. The respondents were all from different denominations and were interviewed using the questionnaire shown in Appendix A.

1.8.4 Healthcare Workers

In October 2017, 10 healthcare workers completed a questionnaire to find out their understanding of religion and spirituality. The participants were recruited using snowball sampling.

The following chapters address each of the study objectives. Chapter 2 focuses on pastoral care for mental health patients. Chapter 3 addresses the contrast between religion and spirituality and their impact on the provision of pastoral care for mental health patients. Chapter 4 addresses the biblical approaches to mental health and argues their applicability to modern pastoral care. Finally, Chapter 5 proposes a framework to improve the efficacy and quality of pastoral care provision in mental health.

CHAPTER 2: PASTORAL CARE FOR MENTAL HEALTH PATIENTS

2.1 Introduction

Southampton is increasingly becoming an ethnically and religiously diverse town affected by psychiatric disparities. The aim of this chapter is to investigate the provision of pastoral care by churches in Southampton to inpatients in psychiatric hospitals. Osmer (2008:43) concentrates on the pastor as a descriptive guide, a position whose relevance in this research is unquestionable. Osmer (2008:48) draws attention to the concept of the “hermeneutical circle" to clarify the relationship between the Descriptive, Interpretive, Normative and Strategic simple tasks. This chapter will answer the question of the interpretive task, asking, “What is it going on?” It describes the rationale and design of current provision of pastoral care to mental health patients, as well as responses of a selected patient group by exploring their mental health needs and roles of church leaders.

2.2 Background

According to the latest census of Southampton (Southampton City Council, 2011), the religious make-up of the city is 51.5% Christian, 32.7% No religion, 4.2% Muslim, 1.5% Sikh, 1.0% Hindu, 0.6% Buddhist, 0.1% Jewish, 0.1% Agnostic. 16,710 people did not state a religion. The people identified as Jedi Knight were 1,388 and 57 people said their religion was Heavy Metal.

2.3 Current Provision of Pastoral Care for Mental Health Patients

Provision of pastoral care to individuals with mental health conditions is identified by Campbell as care “concerned with the well-being of individuals and of communities”

(Campbell, 1987:188). Times have changed from when the hospital chaplaincy only involved allocated clergy from a specific church denomination (the Church of England). Ministers from the Church of England, for instance, were the only recognized ministers placed in hospitals and other public services in the United Kingdom [England and Wales] until between 2003 and 2005. In Scotland, it was only the Church of Scotland until the early 1990s.

The hospital chaplaincy has, however, evolved dramatically over the years and now involves clergy from other denominations and faith groups. Chaplains (also called spiritual advisors) are increasingly becoming part of the teams that provide care both in and outside the hospital. Ministers were paid by the state church, the Church of England, but pastoral care is now heavily dependent on voluntary and other non-profit organisations. This change, therefore, has made pastoral care quite difficult to regulate. The Scottish Government's Guidance on Spiritual Care and Chaplaincy in the NHS[1] in Scotland (2008), as referred to and quoted by Brown (2013:14) had this to say regarding spiritual and religious care:

It is widely recognised that the spiritual is a natural dimension of what it means to be human, which includes the awareness of self, of relationships with others and with creation. The NHS in Scotland recognises that the health care challenges faced by the people it cares for may raise their need for spiritual or religious care and is committed to addressing these needs. Spiritual care is typically provided in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation. Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community (Nixon, 2013:6).

[1] The UK National Health Service.

The aim of pastoral care is to enable a person to discover their sense of hope; it is, therefore, the duty of the pastoral team to bring this out of the individuals. The role of pastoral care has been identified by Brown (2013:14) as care that meets the pastoral and spiritual needs of all faiths, including the patients, service users, their families or carers, and staff.

2.3.1 Inpatients' Views on their Current pastoral care

In psychiatric care where patients experience a wide range of difficulties such as emotional, physical, mental, social and spiritual, care must be given to the patient in a holistic manner. This section presents patients' views on the provision of pastoral care within the inpatient mental health services (see Figure 2.1 and Figure 2.2). Religious communities may interpret mental illnesses differently and may have preferred modes of seeking or providing pastoral care. To be able to engage these communities with psychiatric services, spirituality cannot be ignored.

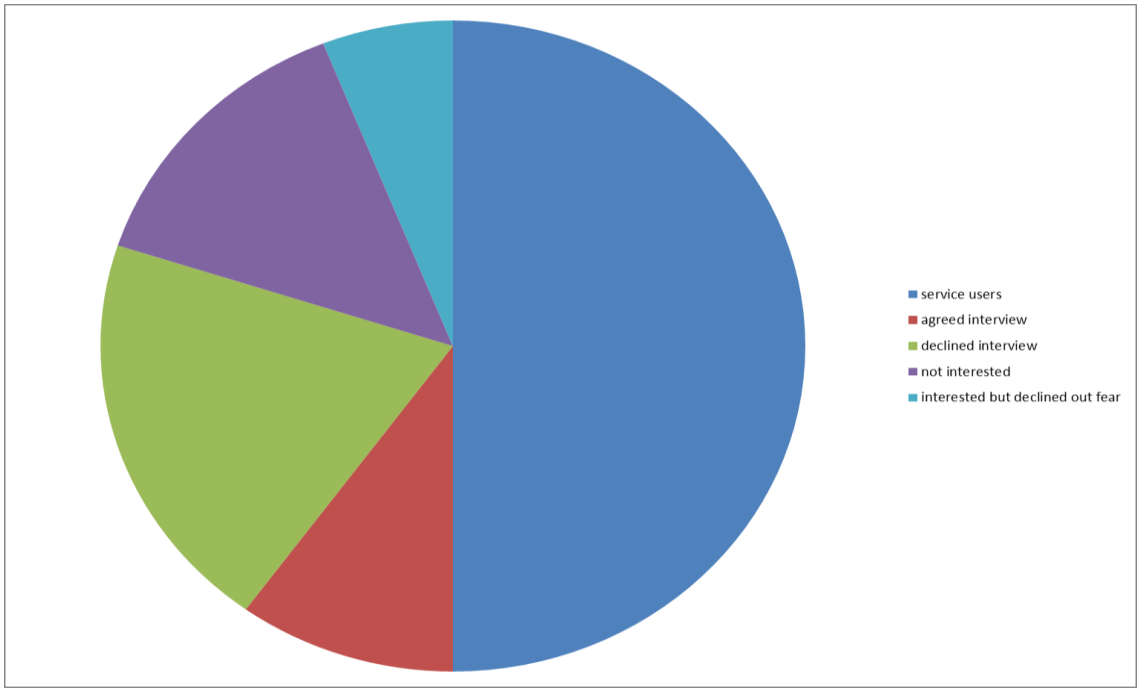

Figure 2.1: Pie chart of participations from interview of individuals in the female ward of the psychiatric hospital in Southampton.

Ten inpatients declined to take part in the interview and even the initial conversation; seven were not interested at all and three appeared to be interested but had some fear of the possible impact my conversation would have on them. The interview process was explained to all potential candidates and it was confirmed that their information would be shared with the University authorities for the purpose of research only. It was also explained to the candidates that interviews could be terminated at any time during the process and they would be allowed breaks if required. All five respondents explained that they found nothing in the hospital environment to help them explore their spirituality apart from their own quiet times.

One lady stated that:

"I would like to see my pastor every week as I did when I was home but they will not let me, they think when I start to talk about my pastor that is a sign that I am not well."

Another young woman stated:

"If you talk about spirituality and spiritualism, they think you're mad… so, my friends, we say 'Don't let on too much'… it creates a barrier between the staff and patients."

Speaking to one woman about her need for spirituality, she stated:

"I usually asked to go to the hospital Sanctuary to read my Bible and to pray but this is not always possible as you will need a member of staff with you. There are no chaplains in this hospital and so if you have any faith, you are on your own."

Southampton's psychiatric services, like most in the UK, experience over-representation of certain community groups compared to others; for instance, patients from the Asian communities are usually underrepresented (Copsey, 1997:13). Interviews with both patients and some church leaders found that spirituality is integral to the mental health of Southampton communities, including White British groups (Lukoff, 2007:644). Young African men, for example, interpret psychotic symptoms within a spiritual framework and advocated seeking help from religious leaders, whilst South Asian patients highlighted faith as a critical component to recovery (Chaze *et al.*, 2015:94).

There were some fears [among patients] regarding talking about those [spiritual] beliefs because it was thought that if they did so, they would either be sectioned, placed on medication, or even seen as exhibiting psychotic symptoms.

The commonly reported view that faith may aggravate mental illness contradicts a growing body of evidence that spirituality is beneficial to mental health and recovery

(Keynejad, 2011:4). Three of the service users[2] who were interviewed by the author explained their experiences of the Church's involvement in their care both in hospital and in the community. Amongst other responses, they said that they dreaded going into a hospital or day centre because there was nothing in those buildings enabling them to express their faith. When asked what they wanted, all the interviewees stated that they wanted a place for prayer, contact with their religious community and staff who wanted to talk to them about their faith.

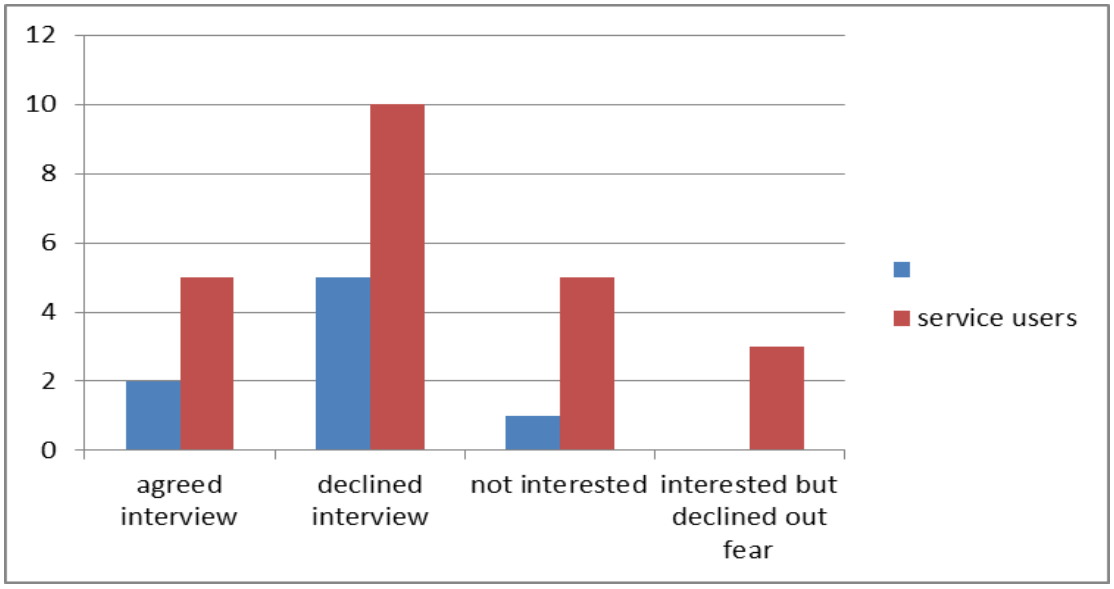

Figure **2**.2: Participation by service users in the interview on Spiritual Benefits to mental health

2.3.2 Outpatients' Views on their Current pastoral care

One service user explained that he believed his experience was not a mental illness, but rather a torment by the devil. He explained the pressure he had endured from his family in the last seven years had been unbelievable as a result of his experiences. He stated that he had moved out of his family home, leaving his daughter and wife to give them a better life, as his wife was not coping with his presentation at home. This had led to his estrangement and alienation from people he loved. He stated that he was unable to go out because he did not want any of his friends to see him. He stated that there was a

[2] Service users are either inpatients or outpatients under the UK National Health Service.

group of them that started together at school and university and they were all doing quite well until his attack. He refused to call his experience an illness, as he strongly believed that it was an assault from the devil. He stated that he was alive because of his twenty-eight-year-old daughter, who was almost due to complete her Ph.D. in Physiotherapy. His daughter visited him regularly, but he was ashamed to have his wife visit because of the state of his flat. He stated that he had met his wife a few times, but only at a restaurant or any other place away from his apartment.

2.3.3 Patients' Views on their respective Religious Groups

There is both academic and psychosocial evidence of the benefits of having faith, especially for people with mental illness. An example of these benefits can be given through psycho-education, which may augment understanding and insight into mental illness and faith (Kehoe, 2007:648). The therapeutic effects of religious architecture, art and music are also supported by Joseph, Linley & Maltby, and 2006:212). It is also believed that religious adherence has links with fewer suicidal attempts (Rasic *et al.*, 2009:40). Faith or spirituality can be crucial to recovery and the rebuilding of a practical sense of self in psychosis (Lindgren & Coursey, 1995:111); however, "spiritual despair" is also documented (Mohr, 2006:1959). Religious involvement is also associated with reduced substance misuse (Dein *et al*., 2010:27).

They expressed these opinions:

- *"I don't feel part of my congregation as I am not involved in anything in the church; people talk about me and distance themselves. I can feel it and it shows in their attitudes when I am being talked about."*
- *"They don't understand what I go through in order to come to Church, I sometimes get to the door and go back home… people even look at you when*

you greet them just because your behaviour was different when you became unwell."

- *"I heard one elder say without realising that I was near them… 'keep an eye on that one because you never know what he will do this time.' I felt like I was only an item in the congregation, I don't feel I belong."*
- *"I know they want to help but certain comments infuriate me, as people do not understand. They say things like, 'we will pray and you will be better', but you know schizophrenia is not curable but can only be managed… I am trying so hard to get used to that notion but …"*
- *"Why should you go to the church? I feel bad enough about myself already. If you don't achieve the ideals we're encouraged to aspire to, you feel guilty."*

The full list of questions posed to interviewees is included in Appendix B.

Guilt and shame about mental illness mean that some will not seek help from their faith community. Others feel more comfortable seeking help from the statutory services rather than their faith community.

2.3.4 Church Leaders' Views

Some of the excerpt comments from participants in the interview are below. Illustrative quotations include:

- *"They come because they feel comfortable and want a resource and I'm not statutory so I can be a bit more approachable, where they feel safe and confidential… there is a real fear of being 'found out'; they do not want to be sectioned."*
- *"She is schizophrenic. When she comes here she is fine, she is included in the prayers. She will not be talked down to; she feels part of the group."*

- *"As a pastor, so many people come to me, especially with jobless and financial problems. They are really depressed and we advise them to pray. We try to help them with readings from the Bible. We advise them to be patient and wait on God."*
- *"Had they not been Christians, some of the people I have seen are convinced that they would have taken their lives, they have not done it because it is a sin to kill."*
- *"Someone who was bipolar wanted something to occupy her, she has some skills, is using them, realises she can make a positive contribution. I see her each week, we have a little session where she tells me what's happening to her and she feels that she can contribute. She is full of energy, but she will rest when I tell her to do so. It is not easy but we have to help her."*
- *"We do not have the time and space in our Church to accommodate people with such difficulties but we are doing our best."*

The interviews revealed that churches provide significant social support to people with psychiatric illnesses. One leader confirmed the importance of having faith and how crucial the roles of church communities are for many individuals and families experiencing distress. Additionally, spiritual practices, from prayer to meditation, provide comfort and a focus on recovery. Faith workers act in emergencies to take care of people in crisis and often play informal roles as counsellors.

Many of the interviewed church leaders were not sure of how to recognise mental illness among their congregants, as opposed to a spiritual encounter. They also requested training on how to support people identified with mental illnesses in their various congregations. They wanted to be more confident in referral so they could encourage the use of services. A prevailing concern was lack of trust in the individuals that come to them. They wanted training from their own community and service users

that include preventative measures, particularly with young people and substance misuse. One pastor intimated, “The church is progressively losing our young people to drugs and alcohol.”

2.4 Conclusion

This chapter focused on the first objective of the study; that is, to examine the present provision of pastoral care for mental health patients.

The chapter described local churches and research evidence supporting the role of spirituality and pastoral care in mental health and recovery. It outlined the rationale, findings, and implications of involvement of faith leaders in meeting the spiritual needs of their congregants in and out of hospitals. It revealed that, despite the government policies and information about the need and importance of pastoral care, there are no longer allocated ministers in hospitals. The complexity of the issue is that local churches are not meeting the needs of their own congregants, let alone volunteering in local hospitals, where the level of pastoral care has declined. This responsibility is gradually being passed on to mental health practitioners, who require pastoral care and significant training of their own.

In view of the above, the study has established that there is minimal provision made by churches for pastoral care for mental health patients.

CHAPTER 3: RELIGION AND SPIRITUALITY AND THEIR IMPACT ON PASTORAL CARE

3.1 Introduction

Osmer (2008:43) describes the interpretive task as seeking reasons for the phenomena that were observed in the descriptive task. The most important question now becomes, "Why is it going on?" This chapter examines the scholarly debate on the differences between religion and spirituality. The question "why?" will help to determine causes for current situations. An attempt will be made to discuss the broader views of the concepts of spirituality and religion and how this impinges on provision of pastoral care.

The chapter will first define terms. Secondly, it will explore the concepts of spirituality in the Bible and attempt to relate spirituality to everyday life. It will also discuss the differences between spirituality and religion and how these are expressed. Finally, it will look at the importance of spirituality and religion in the recovery process of mental health patients.

3.2 Definitions

Despite considerable attempts by scholars such as Schneiders (2000:249), Downey (1997:9), Weltzen, (2011:45), Craghan (1983:24), Baah-Odoom and Wiafe (2016:2415) and many more to make clear distinctions between spirituality and religion, there is still no ultimate and uncontested definition for either concept. The discourse will therefore attempt to contribute to this discussion and to further explore the differences between these concepts. A number of scholars have argued that there is a clear distinction between religion and spirituality. Sulmasy (2009:1638), Mueller, Plevak and Romans (2002:1225), Tidyman and Seymour (2004:33) and others have suggested that religion

is about practices, dogmatism[3] and sacraments; that is, an organised way of worship, whereas spirituality is said to be the way individuals habitually conduct their lives in relationship to the question of transcendence. Schneiders (2000:249) defined spirituality as "the experience of consciously striving to integrate one's life in terms not of isolation and self-absorption, but of self-transcendence towards the ultimate value one perceives".

According to Reid (2006:18), the simplicity of the early Christian church was lost, and rather tied to religious practices that resulted in monarchical, episcopal dogmatism and sacramentalism, which is what appears to be called religion today. Reid therefore describes religion as processes and traditions. In contrast, Baah-Odoom and Wiafe (2016:2414), writing from a Christian stance, describe spirituality as "a set of beliefs, values and way of life that reflect the teachings of the Bible and the way in which Christians express their faith".

3.3 Spirituality in the Bible

Although the word "spiritual" may be vast in its interpretations, it has been defined by scholars in varied ways. Craghan (1983:24) establishes that the Old Testament Jewish believers perceived spirituality to be too encompassing to ever be properly captured in a word or idea. Harper (1987:63) also establishes that the term "spirituality" itself is not a word commonly used by Jews, nor is it a concept given extensive treatment in their religious literature. He continues to say that this is due to their belief that spirituality cannot be captured in an idea or words. Christian spirituality in the context of this paper can mostly be described as a belief system, values and way of life that reflect the

[3] If you're dogmatic, you follow the rules. ... To be dogmatic is to follow a doctrine relating to morals and faith, a set of beliefs that is passed down and never questioned. It also refers to arrogant opinions based on unproven theories or even despite facts

teachings of the Bible and the way in which Christians express their faith (Baah-Odoom & Wiafe, 2016:2415). Christian spirituality is therefore concerned with all of a person's life and how they are connected to God or in relationship with God. The definitions suggest an ongoing means by which a meaningful relationship with God is established and maintained. Religion and spirituality are therefore seen as intertwined. Relationship appears to be important and is demonstrated in the Old Testament as well as in the New Testament. Genesis 2:18 (ESV) infers that relationship has always been part of God's plan. "Then the LORD God said, it is not good that the man should be alone; I will make him a helper fit for him." Martin (2012:11) confirms this by stating that "the first reason for God's creation is that we were created to be in relationship with Him and also with each other". Genesis 1:26 further states the relational nature of God: "Then God said, Let us make man in our image, after our likeness." God is present here as being in relationship, using the word "us" It is very important to see God from the relational viewpoint. "Then the Lord God said, Behold, the man has become like one of Us" (Genesis 3:22a). Also, "Come, let Us go down and confuse their language" (Genesis 11:7), confirms God being in a relationship.

In John 4:23-24, Jesus declares to the Samaritan woman, "But the hour is coming, and is now here, when the true worshipers will worship the Father in spirit and truth, for the Father is seeking such people to worship him. God is spirit, and those who worship him must worship in spirit and truth". Spirituality in both Old and New Testaments appears to be more about a relationship with God than anything else. Welzen (2011:45) referred to spirituality as the lived experiences of the early Christians.

The prayer of the psalter (the biblical book of Psalms) indicates worship with prayers, petition, praise, thanksgiving, and repentance, for example in Psalms 51, 139, 30, 42,

23, 91, 145. These are all indications that God does have dialogical relationship with humans, in which He expresses His intentions for His people among His people. Obviously, it is very easy for Christians to believe that the ultimate value is God. The Gospel of John 4:24 confirms this by stating, “God is a Spirit: and they that worship him must worship in spirit and truth” (English Revised Version). True spirituality is not a human self-help program but rather a divine call or rebirth. Spirituality therefore has to do with holiness, which is the restoration of the human person to who he/she was created to be. Waaijman (2011:1) speaks of spirituality as that which touches the core of human existence, namely “our relation to the Absolute”.

As explained in the earlier discussions, Sulmasy (2009:1638) defines spirituality as the ways in which a person habitually conducts his or her life in relationship to the question of transcendence. It is inherent to perform certain rites and practices in order to attain or maintain spirituality. Furthermore, in the period of the early church, worship was never defined as rituals. One never reads that the church was at a place where worship took place. One never reads where the apostles mentioned “going to worship” in reference to the Christian assembly. The concept of worship that is acceptable to God in the eschatological age is expressed by the author of the letter to the Hebrews: “Therefore, brothers, since we have confidence to enter the Most Holy Place by the blood of Jesus, by a new and living way opened for us through the curtain, that is, his body…” (Hebrews 10:19-20). This implies that being spiritual or religious has nothing to do with dogmatism and practices and places of worship, which most people have tried to avoid in recent years because of the gradual de-connotation of the meaning of the words ‘religion’ and ‘spirituality’. Spirituality can therefore be termed as a manifestation of love that must be accorded to the spiritual being to be worshiped in truth and in spirit,

rather than being centred on rudiments of manmade rules and traditions, which have taken the place of God.

3.4 Religion in the Bible

As has already been established above, religion is said to be practices, dogmatism and sacraments (Sulmasy, 2009:1638). The word "religion" occurs five times in the English Standard Version of the Bible (ESV). It is, by itself, an entirely neutral word. Religion can be related to Judaism (Acts 26:5) or Jewish Christianity (Acts 25:19). Religion can be used in a bad way if it is self-made or for self-gratification (Col. 2:23) and fails to control or tame the tongue (James 1:26). However, religion can also be good when it meets the need of the believers, cares for widows and orphans, practices moral purity (James 1:27) and fulfils the spirituality of individuals. Unless we define the word to suit one's purposes, there are simply no biblical grounds for saying that religion is different from spirituality, because they are intertwined and are inseparable and those who worship God must worship him in truth and in spirit.

Finally, the Bible has implicit evidence to prove that Jesus attended services at the synagogue, as his custom was, and contributed and performed during services as required of him. He observed Jewish holy days. It is quite obvious that He did not come to abolish the Law or the Prophets, but to fulfil what was preached before Him (Matt. 5:17). He founded the church (Matt. 16:18). He established church discipline (Matt. 18:15-20). He instituted a ritual meal (Matt. 26:26-28). He commanded his disciples to baptise his followers and to teach others to obey everything he commanded (Matt. 28:19-20). He maintained that his followers should believe in him and believe in his father who sent him (John 3:16-18; 8:24; 14:1-6). With the above evidence from the Bible, one should be able to understand that if all there is in religion is doctrine,

commands, rituals, and structure, then justice is not being done and religion is not worth serving. Finally, James 2:14-26 tells us that faith without works can be termed as dead faith, since it does not meet the specific needs of individuals. Jesus did not only pray or preach to his followers without providing for their practical needs. Similarly, there could be no spirituality without religion, as these two are inseparable. They build on each other.

3.5 Defining Spirituality in its Generic Term

The term 'spirituality' in its general sense is used more frequently in recent times, for instance, Puchalski (2009:807), Byrne (2007:276), Mattison (2006:31) and Carpenter *et al.* (2008:19), but the exact meanings of the term are often left unarticulated. Researchers such as Emmons and Paloutzian (2003:379) and Hill (2005:65) have suggested that strong, clear and concise working definitions of this concept are required to enable a deeper understanding of what it means to be spiritual. Mohr (2006:175), on the other hand, argues that despite years of debate, there is little consensus on the meanings of spirituality and religion. Booth (1995:5) further contends that the concept of spirituality is amorphous and that it is very difficult, if not impossible, to define. This gives an indication that even among scholars, there is still considerable difficulty in finding one standard definition for this concept. This is due to the closeness in meaning and purpose of the two terms.

In addition to the above, Hyman and Handal (2006:268) and Miller and Thoresen (2003:27) state that social scientists have offered multiple definitions of religion and spirituality, particularly the latter. Even after a considerable amount of empirical research and theoretical contemplation, standard definitions of the terms have not been agreed by most scholars in the field. According to King *et al.* (2017:129), spirituality

means different things for different people. Its meanings also vary across history and across cultures. Corner (2006:12) also expressed that "although expressed through religions, art, nature and the built environment for centuries, recent expressions of spirituality have become more varied and diffuse". However, in literature, spirituality is often described as a search for purpose, connectedness, and wholeness. For Hill and Pargament (2003:63) spirituality is increasingly in everyday use and it is being referred to as the personal and subjective side of religious experience. Mohr (2006:175) states that "although spirituality is a difficult concept to define, it is widely regarded as the sense of relationship or connectedness, which has a source of power or a force, but that force or power need not be a deity". In other words, spirituality refers to an inherent sense of connectedness of the person to a superior force by the way they contribute to one another.

Wanda, as mentioned in Mohr (2006:175), identified spirituality as the experiences or beliefs of an individual in a power apart from his or her own existence. In sum, one can define spirituality to mean an attempt made by individuals to relate their lives to God, a divine being or some other conception of a transcendent reality. In other words, it is a dynamic personal and experiential process. Robinson *et al.* (2003:23) also define spirituality as developing the ultimate life meaning, based upon all aspects of awareness and appreciating the response of others.

This definition implies considering the holistic perspective and embodiment, which involves more than just the intellectual, but also understanding and being aware of oneself.

The healthcare staff were asked the question, “What do you understand spirituality and religion to mean?” Three of the healthcare staff were able to explain the requirement of meeting the holistic needs of their patients, which includes religion and spirituality. However, they were unable to define these concepts and/or account for the importance of religion and spirituality. They did, however, speak about respecting the religious background of every patient. It became evident that these three did not understand the concept of spirituality at all. On the other hand, the remaining seven were able to express their understanding of religion and supported their views with their personal experiences of spirituality.

The Christian leaders explained these concepts as complementing each other. They stated that they are inseparable, as religiosity is the manifestation of spirituality and these two therefore work hand in hand. They further explained that one cannot be spiritual without expressing it. The expression of one’s spirituality is the manifestation of religiosity.

Lastly, the patient group had some difficulties defining these concepts. However, some respondents defined spirituality as “the meaning of life.” When this was explored further with these patients, it became apparent how important spirituality was to them. One particular patient was quite passionate when asked what spirituality meant for her; she stated that spirituality meant the world to her, as life without meaning meant no life to her. The connectedness of religion and spirituality was reflected in some of the interviewees’ responses. One patient described spirituality as a fulfilment of her desire, which was only experienced when she could sing on her own for a period of time. In doing this she experiences an inner feeling that is not normal for her otherwise. Adding to this, she explained that she can only experience this transient spiritual state when she

is engaged in singing certain specific songs, which appear to evoke her spiritual self, which in turn brings some form of physical healing to her.

Another patient explained that she could experience her spiritual self when she was cut off from everyone in the woods, inhaling and exhaling the cold breeze either in the morning or the evening. She also stated that this experience removes her from reality into a state of inertness, where she does not remember or move for a considerable length of time. Such experience brings her some fulfilment and also a sense of healing that transcends all understanding.

On the other hand, a member of the Christian congregation explained spirituality to mean the feeling of fellowship and togetherness, belongingness and a non-judgemental environment, which brings some inner manifestation that he would otherwise not have felt anywhere. In fact, these expressions from the above individuals give us an understanding that being spiritual is "a perception of the commonality of mindfulness in the world that shifts the boundaries between self and others, producing a sense of the union of purposes of self and others in confronting the existential questions of life. It is also an opportunity to provide a mediation of the challenge-response interaction between oneself and others. For some of the respondents, religion and spirituality were intertwined in fundamental ways" (Connelly, 1996).

Furthermore, it became apparent that most interviewees from each of the groups were confused in the first instance and almost unable to differentiate the terms. Some explained that they were quite similar and unable to express it in their own words. However, others were able to express what the terms meant to them, although their answers were completely unrelated to the discourse; it was assumed that this was a

result of their mental state. Others had never considered any differences between the two, or the precise meanings of the terms at all, but on the contrary, others had given the matter a good deal of thought but had not arrived at any conclusions.

3.6 Religion

It has become very popular in today's culture to separate spirituality from religion and make the two as individual and competing entities. Baah-Odoom and Wiafe (2016:2414) refer to spirituality as all that is concerned with developing and maintaining a relationship with God. Grech (2011:4), an Augustinian father and professor of early Christian literature, recognizes no such distinctions between religion and spirituality. The Christian religion, he finds, is infused with spirituality, which he defines not in a New Age sense but rather as the believer's full response to God's offer of salvation in Christ. Spirituality is a gift; it is God's accomplishment. It is not just something you do; it is something you are. God is spirit, and He is unseen (John 4:24). The realm of the infinite God is a higher reality beyond our finite existence (Grech, 2011:8). For one to be spiritual is to engage with God and to live in His immeasurable love. It is impossible to know God but to participate in Who He is.

Although spirituality and religion are usually referred to in this study as socially based beliefs and traditions, which are often associated with rituals and ceremonies (Swinton, 2001:13), and religion typically defined as an organised system of practices and beliefs (Swinton, 2001:14), it has been identified that these two are mutually infused and cannot be separated.

Sulmasy's definition of religion as a set of beliefs, texts, rituals, and other practices that a particular community shares regarding its relationship with the transcendent (Sulmasy,

2009:1638) is not far from that of Grech, who sees both concepts as relational. In addition to the above, religion has also been described as a platform for the expression of spirituality by Sulmasy (2009:1638). However, Mueller *et al.* (2002:1225) explained that "the word religion is derived from the Latin word *religare*, which means to bind together". This implies that religion can be seen as a collection of people with similar spiritual beliefs and practices. Mueller *et al.* (2001:1227) define religiosity as the degree of adherence to the beliefs and practices of an organised religion.

Therefore, considering Sulmasy's (2009:1635) definition of religion as "the ways in which a person habitually conducts his or her life in relationship to the question of transcendence", spirituality cannot be expressed without being religious. Amongst other writers and commentators, religion is considered to denote dogmatism and rigidity, while spirituality is viewed as positive and growth-oriented. Yet, this relatively recent distinction is open to question and criticism (Silberman, 2005:643). These two are difficult to separate, as practices are prerequisite to becoming spiritual. One cannot become prayerful unless one learns to pray. Conviction and conversion can only take place if teaching or learning has occurred. In view of this, spirituality and religiosity may be seen as interdependent and one could not exist without the other.

3.7 Are Religion and Spirituality Conceptually Distinct?

Scholars try to separate spirituality and religion as individual entities. However, the term "spirituality" according to Grech (2011: vii) is rather vague: "Apart from the fact that it relates to all religions, when applied to the New Testament it must be further qualified unless we mean it to comprise the whole of the New Testament theology." Caputo's (2000:1) response to these definitions is that when it comes to multifaceted definitions, whose religion would they be referring to? Grech further explains that the

Christian spirituality includes detachment and self-discipline, as do many religions, and transcendence, as do some philosophies, but the distinguishing feature of Christian spirituality is its relatedness to the Bible. In other words, it refers to an inner contemplation and outer activities that help individuals develop greater self-knowledge and understanding of others, which lead to stronger communities. Certainly, as has already been pointed out earlier on, many efforts have been made to separate the concepts of spirituality and religion, but Howard and Howard (1997:182) describe the concepts as notoriously difficult to define and to separate. Yet, how one chooses to define spirituality, or religion, is critically important because it shapes the way one understands the role of religion in the life of the person and in the society.

Based on the previous postulations, one can explain that spirituality and religion focus on people's subjective perceptions and experiences of something, or someone, greater than themselves, and this may include what is described as corporate aspects of spirituality, such as worship and praise. Although it has become commonplace in contemporary culture to divorce spirituality from religion and to regard the two as separate, it is also evident that spirituality and religion cannot be separated (Grech, 2011:7). Grech (2011) asserts that the Christian religion "is infused with spirituality". Baah-Odoom and Wiafe (2016:2416) also establish that the revelation of God's relationship or fellowship with His creation forms the foundation of the concept of spirituality and religion, or in other words, worship. These three concepts are synonymous. They cannot be separated, as the common thread in all definitions of "spirituality" is "transcendence." One will be required to "connect" to God or a "power." In considering this, it may be suggested that religion brings about order, beliefs, feelings, imaginations and actions that arise in response to direct experience of the sacred and the spiritual.

3.8 Spirituality, religion and healthcare

There have been a number of debates about the major differences between spirituality and religion (Grech, 2011:10; Holder, 2005:16; Hordern, 2016:589). Some scholars have suggested that spirituality and religion both play important roles in the lives of most people, particularly when they are unwell. For instance, Morrison (2008:712), Grainger (1979:44), Willows and Swinton (2000:81), Coyte *et al.* (2007:334), Seybold and Hill (2001:23), Cox *et al.* (2007:22) argue that spirituality and religion have proven benefits to mental health patients as spirituality infers a sense of well-being. A number of scholars in the field, such as Willows and Swinton (2000:82), Orchard (2001:14), Seybold and Hill (2001:24) and Tidyman and Seymour (2004:19), agree that spirituality and religion can play crucial roles in the recovery of psychiatry patients. In view of this, the Department of Health (a UK Government Ministry) has committed itself to an on-going effort to enable faith communities to assist people with mental health, emotional distress, physical discomfort or any form of disability (Seebohm *et al.*, 2005:48).

According to Kühn and Rieger (2017:887), "health is a state of comprehensive and complete well-being of an individual and not just the absence of disease or infirmity". Morrison (2008:2) argues that being a whole person implies having physical, emotional, social and spiritual dimensions. These dimensions should not be treated separately, as psychiatric and other medical discourses may sometimes seek to do. In fact, ignoring any of these dimensions may leave patients feeling incomplete and may even interfere with recovery. Furthermore, Tidyman and Seymour (2004:19) argue that mental health could be better managed by faith leaders, by first improving the level of awareness and being considerate of people with mental health conditions. This awareness would enable congregations to provide an amiable and more inclusive environment for all

people, regardless of their social status, gender, mental health needs and religious background.

3.9 The Importance of Religion and Spirituality

Religion and spirituality have a positive impact on various health conditions including psychiatric illnesses in general. According to Dein *et al.* (2010:63), it is crucial that "psychiatrists respect patients' religious and spiritual beliefs and that these beliefs should be given thoughtful and serious consideration in the clinical setting". Furthermore, according to Hodge *et al.* (2018:2), The Department of Health has recommended to all clinicians to consider patients' spirituality and religious backgrounds as part of their initial assessment (Tidyman & Seymour, 2004:16). Witztum (2011:79) explains that healthcare professionals have now identified the importance of religion and spirituality in the recovery of psychiatric patients, but if clinicians have identified the importance of religion and spirituality in the recovery process of some psychiatric patients, then it is important that spiritual and religious leaders reconsider their role in the recovery journey of the members of their congregations with mental health issues. This will allow such patients access to a continual support mechanism even beyond the confines of their places of worship.

Research has generally shown that religion and spirituality have a positive impact on mental health; for instance, Baetz and Toews (2009:293) and Grainger (2001:37) state that a positive relationship between mental health and spirituality has been established by many scholars. However, it is unclear whether religious leaders recognise this and take advantage of opportunities to reach people experiencing psychological distress or illness. According to Mohr (2006:174), relationships with individual persons should take account of physical, emotional, social and spiritual dimensions. Koenig

(2010:1189) also suggests that ignoring any of the above faculties of a human being can make the individual feel incomplete and unvalued; this can have a negative impact on the recovery process and be reflected in their presentation and behaviour; for example, anger and hopelessness. For Mohr (2006:175), spirituality and religion are very important elements of an individual's personhood.

Jung (1985:68) and Grainger (2002:44) assert that every individual is religious in some sense. Jung further explains that the thoughts of humans encircle around God, just like the planets around the sun. In some cases, psychiatric patients who had made no profession of Christian faith, nor indicated that they had been churchgoers, may present with delusions in relation to biblical passages or things to do with God. It is important that a healthcare professional does not reinforce those delusions. Mohr (2006:174) states that this can be very dangerous. The individual requires assessment in order to ascertain their needs, including spiritual needs, which must be addressed in order to treat the person as a whole.

However, there is extensive evidence, for example, from Bowland *et al.* (2012:74) and Koenig and Larson (2010:1189) that suggests that some mental health patients benefit considerably from having people who will listen to them and allow them to express their religiosity and spirituality. Such so-called 'hallucinations' may serve as opportunities to understand better their worldviews and the internal lives of the patients (Baetz &Toews, 2009:13). It is critical to clarify the values of these individuals in order to become aware of their needs in relation to implementing spiritual and religious intervention, either in hospitals or in religious congregations. Patients feel more valued and respond positively when their spiritual needs are identified and met. As Mohr

(2006:174) argues, psychiatric patients want to be seen and treated as whole persons and not simply as patients.

3.10 How Spirituality is Expressed and its Relationship to Mental Illness

Most western countries are culturally diverse (Fearon, 2003:2). One aspect of cultural diversity is that different groups draw on distinct traditions, which require different approaches to meeting people's spiritual needs. According to Koslander and Arvidsson (2007:598), spiritual care must be open to different ideas about the spiritual dimension in people, especially people with mental health conditions. Spiritual care, or pastoral care, to most people is only about meeting the spiritual needs of their congregations. However, scholars such as Mohr (2006:65) and others have proven that it also involves the socio-cultural.

The interviewed church leaders expressed the need for mental health awareness in their congregations. It became apparent that those leaders who had some experience in the field of mental health illness were more convinced of the importance of mental health awareness within their various congregations because this enables them to understand both the mental health issues and the spiritual needs in their respective congregations. They stated that this has equipped them to address mental health conditions in the same way they would approach any other type of illness. In her book *Ministry of Healing*, White (1942:8) illustrates how Jesus met the needs of people where they were, rather than introducing them to new concepts. She wrote, "He sought access to the people by the path and ways of most familiar associations". Jesus in his ministry appears to have met the physical needs of the people as well as their spiritual needs (White, 1942:8). Luke 10:25-37 is one of Jesus' illustrations to support His point.

Furthermore, it is important for spiritual leaders to understand the nature and severity of the various illnesses and how these can be managed from the spiritual point of view. This particularly becomes complex if the illness is psychotic, with delusions of religious content. According to Grover *et al.* (2014:121) and Koenig (2019:1), religious beliefs are used to cope with the extreme stress that mental illness can cause. “Among the various aspects of religion and spirituality, the influence of religion and spirituality on psychopathology has been one of the most explored areas of research” (Grover *et al*., 2014:119).

In addition, it is difficult to distinguish between delusion and spiritual predispositions (Hordern, 2016:591). In some cases, people present as having special powers or engaging in direct communication with God. They can also claim that they have a message from God, which is to be presented to the congregation, and that they are the only ones with the special calling of God to do this without delay and intrusion. As Mohr (2006:177) argues, psychopathologic distortions of normative religious beliefs can be seen in patients with schizophrenia or bipolar disorder.

Some of these patients may have beliefs triggered by psychotic episodes or any form of psychological disturbance that convinces them that special powers have been given to them by a divine source (Mohr, 2006:177). With a better understanding of mental health issues, religious leaders might be able to pick up any sign of mental health conditions, begin to counsel the individual and encourage him or her to seek medical help. With the individual’s consent, the spiritual leader may be able to refer individuals to the appropriate agencies for further intervention.

Some people think of mental illness as only afflicting a small proportion of the general population. However, many scholars in this field believe that mental illness or psychological distress can be suffered by anyone. Mohr (2006:154) explains that highly stressful life events can transform normative religious beliefs into excessive preoccupations that involve self-blame and guilt over real or imagined transgressions. Patients can be influenced by psychotic distortions that involve religious themes either for themselves, fellow believers or congregations. In some cases, very depressed people will blame themselves and attempt to punish themselves for this. At times, this can lead to suicide if not detected in time and prevented.

In addition to the above, Richards and Bergin (2011:56) argue that spiritual interventions and exploration can be relied on more readily in less disturbed patients. This implies that it is crucial for ministers to be aware of mental health conditions and that, in order to address these problems, they should be able to identify mental illnesses in members of their congregations at the earliest onset. Spirituality extends profoundly into the heart of every person and also goes far beyond the physical world. Spirituality connects individuals with the divine through developing a deep and personal relationship with the divine. Whichever way this may be perceived will depend on the quest of the individual. This may include looking for success, academic advancement, inner peace, or supreme enlightenment. No amount of information can drive one to achieve one's goals in life or offer a real plan for living more persuasively than spiritual knowledge does. Although spirituality appears to have been given more attention than religion recently, they are inseparable. It may be seen as the more general term but it cannot be expressed without religion. The difference between religion and spirituality is simply that most religions offer a specific set of beliefs and structures to help people to attune to their innate spirituality. Religion and traditions certainly work alongside each

other and this may include individual spirituality. However, each religion has its own separate style of worship, beliefs, texts and doctrine. Spirituality is usually defined by individual, particular religious groups as deemed fit. Although culture and traditional beliefs can play a part in the way spirituality is expressed, the intensity of these depends on a person's own convictions. Spirituality is a way to connect to a particular deity; for example, through prayer the Christian community connects to God. Others connect through meditation, and some through inflicting pain on themselves.

3.11 Conclusion

This chapter addressed objective 2 of the study. It assessed the difference between religion and spirituality and its impact on provision of pastoral care for mental health patients.

It has become commonplace in contemporary culture to separate spirituality from religion and regard the two as separate and competing spheres. A great number of attempts have been made to define both religion and spirituality as separate concepts. Attempts have also been made to detach spirituality from religion in order to support the belief that one can be spiritual without being religious or believing in God or a higher being. Other attempts have been made to defame religion by describing religion as dogmatic and sacramental.

This study has established that the difference between religion and spirituality is minor. Spirituality is the relationship between an individual and God, whereas religion is the environment within which spirituality thrives. Religion and spirituality are interdependent and infused. It has also been established that God is relational. The word

“religion” is linked to bringing people together to God and deepening intimate relationship, where energy is directed toward serving others.

Pastoral care is negatively impacted due to the neglect of its religious aspect. This has led to a form of humanistic approach to spirituality, which eventually leaves God out of pastoral care.

CHAPTER 4: BIBLICAL BASIS FOR PASTORAL SUPPORT OF MENTAL ILLNESS

4.1 Introduction

The central argument of this research is that psychiatric patients need spiritual attention to maximise their chances of improvement or recovery, for which the churches in the UK need to make effective provision. Osmer (2008:32) concentrates on the pastor as an interpretive guide, a stance that has obvious relevance to this research. Osmer (2008:32) draws attention to the concept of the "hermeneutical circle" (or better still, the "hermeneutical spiral") to clarify the relationship between the Descriptive, Interpretive, Normative and Strategic pastoral tasks. This chapter will be answering the question "What is going on in the Bible concerning mental illness?" which forms a key part of this research.

This chapter will explore biblical scenarios of what appears to be mental illness in both the Old and the New Testaments. First, the study will critically explore some possible examples of mental illness in the Old Testament.

Second, the illness of King Nebuchadnezzar the King of Babylon in Daniel 4 will be explored. These will then be compared with an account of an unnamed man in Mark 5:9 and Luke 8:30 in the New Testament.

From a pastoral care perspective, people with mental health conditions require pastoral care. Churches today have a big role to play in meeting the needs of those people with mental health conditions. This study also seeks to explore the basic definitions and

understand the importance of pastoral care for people with mental health conditions in church congregations.

4.2 Background

It is obvious that healing presupposes the presence of a disease or diseases. A disease, according to Johnson (2005:89) is a term that describes medical and physiological difficulties. In other words, it can be described as a physiological degeneration of, or a morbid change in the bodily tissues, which leads to adverse changes in the body or mind.

Medical evidence also demonstrates that pathological agents cause disease or illness to the host. The term is most often used for agents that disrupt the normal physiology of a multicellular animal or plant, in other words, a living cell. According to Johnson (2005:90) the ancient pathological concept of disease was the idea that the gods had punished people with these diseases because of certain violations of taboos, laws or religious codes (Exodus 32:33-35).

The idea of sickness and healing in the Old Testament can be traced as far back as Job, where sickness, sin and healing emerge. It is evident that the biblical text does suggest that diseases were sent by God to punish people for transgressions. It is also evident that some texts suggest that diseases can be expressions of God's wrath in response to sin (Deuteronomy 28: 38-45).

The ancient Jews did not go to the physicians when they become ill, but they rather went to the priest. There are only a few references in the Bible to people visiting physicians. Job mentioned the existence of physicians when he said, "You are all

physicians of no value" (Job 13:4). Job did not place these physicians above God and, more so, placed no confidence in them, as he attributed all things to God (Job 1:21 and 22; 2:10). King Asa was also criticised by the sacred writer, who said of him, "He sought not to the Lord but to the physicians" (Chronicles 16:12). Jeremiah the prophet of God asked, "Is there no balm in Gilead, is there no physician there?" (Jeremiah 8:22). It was customary for the Jews to attribute healing to God who according to them was the only true healer.

The New Testament has a few references to physicians: "Physician, heal thyself" in Luke 4:23; also, there were physicians in Galilee who received fees for their services, for instance, the example of the woman of Caesarea Philippi who had the issue of blood (Mark 5:26; Luke 8:43). There are also several Talmudic references to physicians; in *Sheqalim* ii 1, it is said that there was a physician at the temple who attended to the priests. Physicians and healers were appointed in every city by the high priest (Gittin 12b), who was required to have a license from the authorities (*Baba Bathra* 21a).

In addition to the above, Luke, called "the beloved physician" in Colossians 4:14, is said by Eusebius to have been a native of Antioch and a physician by profession. Origen describes him as the unnamed "brother who was praised in the gospel [2 Corinthians 8:18] and his praise spread through all the churches". His professional studies are demonstrated in the language of his writings, though of this probably more has been made by Hobart (2004:2) and others than it really merits. Keener (2016:209) calls attention to the two words used of the healings at Melita in Acts 28:8-10.

To understand the biblical records concerning illness, it is necessary to imagine a world that knew nothing of germs, bacteria, viruses, antisepsis, anaesthesia, the circulation of

the blood, or the precise difference between catalepsy, “clinical death”, coma, and “final death”. Disease was literally a consequence of disobedience to the divine law. It is very important to understand the thought processes of the ancient world as confirmed in Genesis 3:17-19. To disobey God is to become imperfect, which eventually results in death that was passed on to the human race by the sin of Adam (Genesis 3:17-19; Romans 5:12). God directly “touched Pharaoh and his household with great plagues because of Sarai, Abram’s wife” (Genesis 12:17). Admittedly, God was responsible for the “boils with blisters” that broke out on both men and beasts during the sixth blow He inflicted upon ancient Egypt (Ex 9:8-11).

He taught the insolent Miriam a lesson by striking her with leprosy (Numbers 12:9-15). King David suffered for his unfaithfulness by the death of his illegitimate child by Bathsheba (2 Samuel 12:15-18) and “caused a pestilence in Israel” during David’s day (2 Samuel 24:15). These acts happened so that God’s name might be glorified with His laws and statutes. They were also for the liberation of His chosen people and/or for the protection of fatherly discipline. Hence, the people interpreted King Saul’s illness (what appeared to be madness) as a punishment from the God of Heaven for his disobedience to God’s law (1 Samuel 16:14 and 15). An example of an illness that was perceived as a punishment from God is in 1 Samuel 16. The Old Testament narrative of King Saul, the first king of Israel, who reigned in Jerusalem from 1029−1005 BCE (Amit, 2000:170), is described in 1 Samuel 15:11, as disobedient. His actions are described as regrettable.

During his last years on the throne, King Saul became very preoccupied and obsessed with his thoughts as he was informed of the loss of his throne. He seemed to know his successor was to be his servant, although he would have preferred his own son to

succeed him. Although his illness was linked to disobedience, there is no evidence in the text (1 Samuel 15:27-29) to suggest that God punished Saul with an illness, but rather with the loss of his throne. The prophet Samuel turned to leave but Saul caught hold of the hem of his robe, and it tore. The prophet exclaimed to him, 'The Lord has torn the kingdom of Israel from you today and has given it to one of your neighbours to one better than you. The Glory of Israel, He does not lie or change his mind; because God is not a human being, He does not change his mind.

King Saul was greatly troubled and became paranoid and suspicious. The increased fame of David, Saul's musician and armour bearer (1 Samuel 16:21, 23), severely distracted and depressed him (1 Samuel 18:9, 28, 29) (Beale & Carson, 2007:314; Knoppers & Edelman, 1995:122). Saul received care from David through music (1 Samuel 16:23). David played the lyre for the King when "the evil spirit from God" came upon the King. There was relief for King Saul with the music from David. The biblical accounts clearly demonstrate that the he became relieved and he would feel better. Whether this can be classed as pastoral care or not is debatable, as we shall be exploring the meaning of pastoral care by looking at some definitions. The king was ministered to through music when he became distressed. Music therapy has remained an effective therapy for some mental health cases. Levitin conducted research in neurochemistry and reported that:

There is a compelling evidence that musical interventions can play a health care role in settings ranging from operating rooms to family clinics. Even more importantly, we were able to document the neurochemical mechanisms by which music has an effect in four domains: management of mood, stress, immunity and as an aid to social bonding (Glynn, 2013:2).

Although there is no evidence to suggest that drugs were considered in this matter, music seemed to be successful in this sustenance of stability in Saul's mental state. Second, Daniel 4 highlights another character who, it has been suggested, developed what appeared to be mental health illness after disobeying the God of Heaven. The contrast here between the episode of King Saul and King Nebuchadnezzar is that King Nebuchadnezzar was informed of the consequences of his actions and the pronouncement of this was specific and time bound. The strange phenomenon of his changed behaviour was said to have come from God as a punitive measure for disregarding and not acknowledging the God of heaven as the superordinate (Daniel 4:23-27). By contrast, King Saul's punishment was the loss of his kingship for disregarding the instructions of God, but there was no mention of an illness from God (1 Samuel 15:23). Saul's change in behaviour, noticed by his counsellors, appeared to be in response to the pronouncement from the prophet Samuel. God took away that prudence, courage, alacrity, other gifts and the assistance of God's Spirit, with which He had equipped him for the management of his public duties.

On this basis it is quite difficult to class Saul's illness as a punishment from God. Although 1 Samuel 16:14ff states that an evil spirit from the Lord replaced the good spirit, this statement was only based on the changes that appeared in Saul's behaviour, as opposed to the pronouncement from God by the prophet Samuel. One can therefore argue that although mental illness was a phenomenon during Bible times, the symptomatic presentation of the King depicted what can be described as a mental health problem.

One may also argue that the definition of mental illness in the then world may have been perceived differently from the current era. Mental illness appeared to be perceived

as phenomena directly caused by the actions of God, or the gods. On the contrary, there was evidence that King Nebuchadnezzar in Daniel 4:23-26 had a change of behaviour in response to the pronouncement of punishment.

The third character, described in the New Testament, is the demoniac, who was said to be possessed by an evil spirit, although it is a similar presentation to one with mental illness (Luke 8: 26-39, Matt 8:29 – 9:1; Mark 5:1-20). There seem to be no questions about his possession as his response to Jesus's appearance (Mark 5:7) demonstrates his acknowledgement of Jesus as the Son of God. However, his brief experience and encounter with Jesus was certainly enough for him to receive the needed healing.

4.3 Mental Health and the Bible

Saul's behaviour has been described by scholars such as Tanner (2010:14) as so much like that of people with mental illness. Mental disorders, according to Manjunatha and Chaturvedi (2016:518), comprise a broad range of problems with different symptoms. However, they are said to be generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, learning disabilities and other disorders due to substance abuse or other factors. The National Alliance on Mental Illness (Duckworth, 2013:2) defines mental illness as a psychological condition that interferes with a person's thinking, daily living conditions, feelings, mood, ability to relate to others and daily functioning. These illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. One cannot be far from diagnosing Saul, Nebuchadnezzar or the demoniac in the New Testament with these depredating conditions, as their lives were slowly disappearing before their own eyes.

Some interpreters have proposed diagnoses for Saul, such as "anxiety disorder featuring panic attacks" (Esler, 2010:249), "fits of depression," "depression and paranoia," or "perhaps manic depression" (Craigie, 1988:329). Others, while not attempting a diagnosis, (Avalos *et al.*, 2007:2; Payne, 1982:84) speak in terms of mental illness; for example: "madness" (Gunn, 1980:81), "troubled," "disorder" (Klein, 2002:165), "psychological illness", "inward feeling of depression … which grew into melancholy and … passing fits of insanity" (Keil & Delitzsch, 2002), "a gloomy, suspicious melancholy, bordering on madness" (Young, 1962), "melancholia" (Tsumura, 2007:429), "mental disorder" benefitted by "music therapy" (Bar-Efrat, 2004:592), "cerebral disease", "unhingement of mind" (Spence-Jones & Exell, 2004:314) and "a mental illness" (Hauskeller *et al.*, 2015:172).

Further examples include mental illness, which may include "anxiety disorder featuring panic attacks" (Esler, 2010:103), "psychosis which is evidently presented with delusional beliefs, hallucinations and at times fits of depression which can be accompanied by paranoia" (Alter, 1999:78), also a sense of being controlled by external forces, a symptom of schizophrenia (Knowles, 2001:123). To argue that Saul's behaviour was not a result of mental illness would miss the point. His behaviour suggests mental illness, and generations of interpreters and readers have made the association. Regardless of whether Saul was mentally ill or not, the persistent association of his condition with mental illness and of mental illness with an evil spirit from God is undisputed. Although the text never says that Saul was mad, the narrator appears to know the terms "mad" and "madman" and uses them in the midst of this narrative to describe David's feigned madness before King Achish (1 Samuel 21:13ff).

Even the king's moody temper, not to say frequent fits of insanity, would alone be sufficient to explain insanity let alone the circumstance of his not recognizing a youth

who, during the time of his mental aberration, had been often near him, trying to soothe his distempered soul (Jamieson & Jamieson, 1997:36).

The author of 1 Samuel may possibly have omitted madness because of Saul's royal status. Alternatively, this omission could be due to Saul being the anointed one of God, as David alluded to in 1 Samuel 24:5. The king was untouchable, just as the writer was unable to label him with madness.

The intervention used in treating Saul's malady (music therapy) makes it quite apparent that mental illness was not a new phenomenon, as his Council knew exactly what remedy to use. It would appear that music therapy played a major part in the treatment of the King's illness. However, no other treatment options appear to have been explored or mentioned.

4.4 Daniel 4

There are many types of mental illness and, depending on how mental illness is described, 10 to 25 % of people living in the United Kingdom can be considered to have had a mental illness at some point in their lives. Like many other illnesses, it is common and can occur at any time and happen to anyone. According to Clare *et al*. (2017:98), severe mental illness is a term used for longstanding conditions and affects only about one percent of the population. There are many types of mental illness, but the easiest way of defining them is as either psychotic or neurotic.[4] Most conditions fit into either of these categories.

[4] Neurotic disorders are considered to include somatization disorders, post-traumatic stress disorder, panic disorder, anxiety disorder, phobias, dissociation disorder, obsessive-compulsive disorder, adjustment disorder and others. First (2009:386) identifies F23 acute and transient psychotic disorders (five criterial). ICD- 10 includes four disorders (some with duration of up to 3 months) that differ based on type of psychotic symptoms (this can be with or without schizophrenia). Psychotic disorders can

The Babylonian king, who reigned from 605-562 BCE (Byers, 1998), built the Hanging Gardens of Babylon (Comay, 1995; Gardner, 1995). He also suffered from what appeared to be mental health conditions and was said to have been punished for his pride and vanity. He has been said to be afflicted with a disorder akin to the modern concept of lycanthropy (Durante, 2006; Garlipp *et al*., 2004; Hays, 2007; Souvay, 1911:425; Stone, 2006; Tischler, 2006), believing for seven years that he had been turned into an ox (Daniel 4:33).

The central theme of the story of King Nebuchadnezzar, who found solitude in the wilderness and turned into a wild man, has been called "a medieval version of madness" (Bartra, 1994:64). Bartra explains that not every aspect of the narrative in Chapter 4 has received equal attention. Aspects such as the bestial transformation of the king form the very core of the exegete's interest.

Many critics have disputed the historicity of the events depicted in Daniel, because of their unbelievable nature or because they could have been written much later than the events depicted in the biblical accounts. There is also some discussion as to whether the government could have maintained itself with its leader decommissioned. The case of King George III, "the Mad King" of Great Britain (1738-1820) and that of Ronald Reagan (1911-2004), the 40th U.S. president, who likely suffered from Alzheimer's disease during his presidency, have shown that an effective staff can run a government with a side-lined figurehead. Nebuchadnezzar was known for selecting an elite staff, as evidenced by the process by which he selected Daniel and his friends (Daniel 1:3-7).

present in an acute phase which can be severe in nature. This is a mental disorder that causes impairment of perceptions. It is normally characterised by delusions and hallucinations.

There is a conspicuous absence of any record of acts or decrees by Nebuchadnezzar from 582–575 BCE (Archer, 1994:63). Archer also referred to Berossus, a Babylonian priest and astronomer of the third century BCE, who documents that Nebuchadnezzar became suddenly ill after forty-three years in power. Eusebius was also referred to (263–339) in a report from the Greek historian Abydenus that validates the biblical account, saying that Nebuchadnezzar was "possessed by some god or some form of deity". In addition, a clay tablet housed in the British Museum known as BM34113 (lines 3, 6, 7, 11, 12, 14) describes Nebuchadnezzar as exhibiting irregular behaviour, noting that "his life was of little value to him." The Aramaic fragment excavated from Qumran Cave 4 in 1952 accredited to Babylon's last king presumed to be Nabonidus (556–-539 BCE), is actually a distorted tradition of relaying the illness of Nebuchadnezzar (Archer, 1994:64).

The reader of the book of Daniel is not intended to have sympathy for the foreign dictator; however, it does appear that Daniel had compassion for the King and encouraged him to change his ways by his interpretation of the dream to influence the behaviour of the King. Nebuchadnezzar is dehumanized, as he is said to have eaten grass like a bovine, grown hair like the feathers of an eagle and nails like the claws of a bird (Daniel 4:25, 32, 33).

The implication is clear: Nebuchadnezzar became less than human. No other human eats grass in the Bible. To eat grass like a bovine may even have been a colloquialism, as it is used with three different nouns, all meaning bovine: "shower" (Numbers 22:4, Psalm 106:20), "baqar" (Job 40:14), and the Aramaic "tower", found only in Daniel

(4:25, 32, 33, 5:21). In temporarily dehumanizing the arrogant ruler, God removed Nebuchadnezzar's power.

Nebuchadnezzar states in Daniel 4:2 that the Most High God performed these miraculous, wondrous signs on his behalf, which means that the king had a personal experiential knowledge of the God of Israel, like Daniel and his three friends.

Daniel 4 depicts a holy watcher from heaven, who decrees that the Babylonian King Nebuchadnezzar's "mind be changed from that of a human" to "the mind of an animal" until an object lesson is learnt. According to verse 16, King Nebuchadnezzar acknowledges and expresses the authority of the "Most High", who assumes the position of a sovereign over the kingdom of mortals. It is implied by v. 30 that Nebuchadnezzar imagines that his own wisdom and power have propelled him to the pinnacle and valour of kingship and not God. This is the king who stated (2:47), "Surely your God is the God of gods and the Lord of kings and all-knowing God who helped you tell this hidden secret". He now quickly forgot about this and exalted himself and gave all credit to himself as the source of his own might and glory (v. 30). He must have believed that Daniel's God was like one of the Babylonian gods, for it was normal for the Babylonians to believe that "the revelation of supernatural mysteries belonged to the gods and Daniel must possess the spirit of the gods" (Keil & Delitzsch, 2002:147). Daniel's insight into the spiritual realm did not convert Nebuchadnezzar from his beliefs in multiple gods or his belief in the supreme Babylonian god Bel. By acknowledging Daniel's spiritual abilities, Nebuchadnezzar was not acknowledging the supreme God. Daniel was troubled because he knew that the message of Nebuchadnezzar's dream was not good.

Daniel was struck with amazement and terror at the magnitude of judgment that was coming upon such a great ruler. He broke the bad news with tenderness and respect. He had deep concerns and compassion for the king. He prepared the king by delaying in giving the interpretation, saying, “If only the dream and its interpretation was for those who hate you” (4:19). It may appear that Daniel feared for the king’s reaction if he dared to foretell the king’s overthrow. He knew he must announce to Nebuchadnezzar the judgment of God that was to come upon him. Nebuchadnezzar noticed Daniel’s concern and appeared to believe that Daniel had the correct interpretation of his dream. He asks him, with a friendly address, to tell him the interpretation without reservation. Daniel relays the information to the king in such an affectionate way and shows his interest in the welfare of the king. He desired that the interpretation of the dream not come true for the king, but rather for his enemies.

Nebuchadnezzar II (634-562 BCE), king of the Neo-Babylonian Empire, is remembered as one of history’s great leaders. In the Bible, he is known simply as Nebuchadnezzar and portrayed less favourably. The book of Daniel depicts Nebuchadnezzar as an arrogant ruler who demanded worship of himself (Daniel 3:4-6). The book tells that God humbled the monarch at the height of his power. Nebuchadnezzar’s insanity has been described by scholars as sensational, in the sense that four symptoms are presented.

First, a loss of reasoning (Daniel 4:16), being drenched in the dew of heaven (Daniel 4:15, 25, 33), living and being exiled with animals (Daniel 4:16, 25, 32, 33). Secondly, a change in dietary patterns to the extent of eating grass (Daniel 4:25, 32, 33); this was the king who had ordered his servants in Daniel 1:5 to assign Daniel and his friends special food from his table and thirdly, Nebuchadnezzar’s exile and his lack of hygiene

may indicate that the ruler was completely unrestrained. These symptoms persisted for the ambiguous duration of "seven periods of time" (Daniel 4:16, 23, 25, 32). This could mean seven years or seven months, but given the number seven's association with completeness in Hebrew writings, it may simply mean that the length was sufficient to accomplish God's purpose(s).

Scholars such as Jung (1966:993) argue that though these symptoms are curious, they are not entirely unique in the annals of history. Using modern psychological terminology, it appears that Nebuchadnezzar represents a textbook case of boanthropy. This is a rare psychological disorder in which a human being believes himself to be a bovine or herbivore. Dreams are known to play a part in this malady. Harrison (2004:1116) provides an account from physician Raymond Harris on his experiences with a man suffering from boanthropy in a British mental institution as follows:

A patient was in his early 20s who reportedly had been hospitalized for about five years. His symptoms were quite evident on admission, and diagnosis was instantaneous and decisive. He was of average stature with good physical presence. His mental symptoms included pronounced anti-social tendencies, and because of this he spent the entire day from dawn to dusk outdoors, in the grounds of the institution... His daily routine was walking around the premises with the magnificent lawns. He would normally pluck up and eat handfuls of the grass as he went along. On observation he was able to carefully select between grass and weeds, and on inquiry from the attendant the writer was told the diet of this patient consisted exclusively of grass from hospital lawns. He never ate institutional food with the other inmates, and his only drink was water… The writer was able to examine him cursorily, and the only physical abnormality noted consisted of a lengthening of the hair and a coarse, thickened condition of the fingernails.

Gleitman, a cognitive psychologist, speculates that Nebuchadnezzar exhibited features of an advanced syphilitic infection (Gleitman *et al.*, 2011:219). Jung (1875-1961) addressed Nebuchadnezzar in many of his works. He diagnosed the ruler with a "classic case of megalomania". Jung analysed Nebuchadnezzar's dream writing and reported that it was "easy to see that the great tree is the dreaming king himself." Daniel interprets the dream in this sense. Its meaning is obviously an attempt to compensate the king's megalomania, which, according to the story, developed into a real psychosis (Jung, 1989:37).

This reading views the dream as an exemplar of a compensatory dream, a dream by which the dreamer offsets a disproportionate sense of power. Nebuchadnezzar's vision of the tree being cut is what his psyche deemed must happen for him to achieve any semblance of 'wholeness'. Whether or not one consents to Jung's interpretation, his summary of Nebuchadnezzar's condition is seemly: "a complete regressive degeneration of a man who has overreached himself" (Jung, 1989:123).

However, one fact that stands out with the episode of Nebuchadnezzar is that it was a direct pronouncement of God and it was time-bound. The illness of the King is archaeologically confirmed by the discovery of a bronze door-step, which bears an inscription stating that it was presented by Nebuchadnezzar to the temple at Borsippa as an offering because of his recovery from illness (Tabouis & Hanotaux, 1931).

In view of this, one could conclude that Nebuchadnezzar's experience in the wilderness could not have been a mental breakdown of any kind, since his experience was specific to a time, place, and presentation. It is impossible to set a date or a time frame for an individual to have a mental breakdown and then regain their sanity once the time is up.

One could not have been as specific with time, place and exact description on his presentation as occurred in the case of King Nebuchadnezzar. However, pastoral care was inevitably crucial in this matter, as he needed understanding of his dream, which of course he could not remember. The king used all his counsellors and sorcerers but found no answers. Pastoral care is now seen from the psychological point of view and usually seen as a problem-solving ministry, where individuals present their problems and pastors will help resolve their problems (Louw, 2012:70). Daniel, however, identified a channel of attaining spiritual wisdom and presented God as the source of answer to all problems.

4.5 Pastoral Care

Caring must be an essential ingredient, DNA and fabric of every congregation and members must identify this at the earliest opportunity possible. Caring must not be limited or stereotyped, but it must reach the totality of the person. Pastoral care is not limited to one faculty of the person but to the totality of the soul. It encompasses the practical and the spiritual in its reach but also the psychological in its approach. Oates (1970:3) compares pastoral care to a unifying force that confronts and challenges persons in times of crises. Hamblin (1993:4) defines pastoral care as a response to the need that everyone has for warmth, nurture, support, and caring. Many who seek a pastor's help are not a part of any church or other caring community. They are the lonely and alienated in our society whose need for caring is acute.

In addition to the above, Fisch and Bruera (2003:124) explain pastoral care as an active and purposeful concern for people, especially in the realm of ultimate meaning and value.

Pastoral care in the broadest sense is said to cover religious and spiritual matters, but not evangelism. This includes looking after the sick and the needy unconditionally. One can also argue that, even within Christianity, the notion of pastoral care has been fairly fluid through the centuries and also between different denominations. Pastoral care has no subject other than Jesus Christ and no content other than the faith that was entrusted to the believers (Carrol, 2010:146). This is not to say that pastoral carers cannot do anything without Christ but to demonstrate the love that Christ demonstrated in his ministry. Christian pastoral care givers have nothing more to offer but Christ and the only hope a risen saviour. Peter and John present a practical example in (Acts 3: 4-7) "And fixing his eyes on him, with John, Peter said, "Look at us." He gave them his attention, expecting to receive something from them. Then Peter said, "Silver and gold I do not have, but what I do have I give you: In the name of Jesus Christ of Nazareth, rise up and walk." He took him by the right hand and lifted *him* up, and immediately his feet and ankle bones received strength".

One cannot deny the focus on pastoral care when Jesus states, "I am the good shepherd" (John 10:11). The shepherd is a person who guides the sheep to the streams of living waters, who forgives sins, and who heals and brings life out of death. The term "pastoral" in pastoral care, according to McLemore (2012:3), comes from the Latin *pastorem*, meaning "shepherd" and includes in its deep etymology the tending to the needs of the vulnerable. Since the Hebrew Scriptures and the New Testament were products of pastoral societies, it is perhaps not surprising that the metaphor of the shepherd emerged as a principle image for religious leadership. It has therefore become apparent that caring for someone must include the notion of affection, solicitude, accompaniment and protection. In both Genesis and Exodus, care appears to be focused more or less within family units; for instance, in Genesis 14, Abraham's resolve to

rescue his nephew Lot was due to his concern for Lot's well-being. In Exodus 18, Moses was persuaded by his father-in-law not to try to be the sole arbitrator in resolving all disputes at the camp, but rather to develop a suitable system by creating smaller units. This underscores the importance of pastoral care needs in smaller units, such as family.

The regulations about the examination of the people suffering from skin diseases and complaints (Leviticus 13:17, 21, 36, and 14:44) also imply that the priests were readily available for the concerns of the people, even with their health needs. This is also an indication that the priests had at least that rudimentary medical knowledge which is used to provide both medical and pastoral care for the people. It is, however, not clear whether this was on a professional level or not, but it was the responsibility of the priest to determine whether an individual had been cured from illness.

Furthermore, it is not clear whether the priest's medical knowledge was used to effect cures of illness as well as to diagnose them, but it was believed that the priest was able to support the sick. According to Johnson (2005:37), the ancient Israelites were keenly aware of nature and were also attuned to natural phenomena. The skill of empathy and the awareness of being in the image of God and thus being able to look beyond the observable and hear beyond the verbalised sounds was a skill that the priests used to their advantage (Johnson, 2005:38). For instance, the prophet Isaiah states in Isaiah 50:4-5, "the Lord has opened my ears." This does not seem to mean the opening of the physiological ears, but rather an acknowledgement of being able to hear the Lord. The prophet demonstrated that responding is a result of listening and listening is the ability that is provided to him by God.

Johnson (2005:39) states that God and humans are partners in the healing process and to deny one at the expense of the other is to deny a significant reality in pastoral care. Cooper *et al*. (2013:1059) also states that pastoral care is that ability to stop, look and listen before proceeding to do something that enhances the quality of pastoral care.

According to Dowd and Malbon (2006), Jesus had no martyr complex but rather demonstrated selfless love that propelled him to serve others, especially the marginalised in society. This may have been difficult in a conventional society where rightness was judged as if it were based on status. As Jesus' approach was contrary to the norms of the then society, even good services resulted in suffering and death at the hands of the powerful of that society. "For even the Son of Man did not come to be served, but to serve, and to give his life as a ransom for many" (Mark 10:45 NIV). The Gospels picture Jesus teaching in the temple, by the sea, on the mountainside, and in the great thoroughfares of travel. He is seen at the bedside of the sick and speaking peace and hope to the afflicted. He went about doing good, comforting the mourners, helping the helpless, healing the wounds that sin had made. It was in the same vein that Christ met the demoniac and healed him of the pain and the chains with which the devil had estranged him.

4.6 The Demoniac

A "demon-possessed man" would have been a reference to a person who was made insane by demonic forces (Ferguson, 1984:2). However, Cogan and Lint (2004:2) state that the use of the term "demon-possessed" was uncommon in the Hebrew Scriptures and the relative scarcity of demonic spirits in the Hebrew Scriptures might have been caused by the Hebrew nation's strong monotheistic beliefs. The story of the Gergesene demoniac is thoroughly shaped by Jewish norms. Luke 8: 26-39, Matthew 8:29 – 9:1

and Mark 5:1-20 all record this incident. Matthew's account is shorter and involves two demoniacs, while Luke's account is closer to Mark's in context. In Luke 8:26b the region of the encounter is said to be "opposite Galilee"; spiritually as well as geographically, it is a Gentile country. This man was "driven by the demon into the desert"; however, Luke 8:29 states that this man now sits peacefully at Jesus' feet. He was naked, but now is clothed. He was subject to wild, self-destructive behaviour, but now is "in his right mind". In v. 36 Luke presents this as a holistic healing. This man had received physical, mental, emotional, social, and spiritual healing.

4.7 Exegesis of Passages

The Talmud illustrates four characteristics of madness: walking abroad at night; spending the night on a grave; tearing one's clothes and destroying what one was given. This man demonstrated all four characteristics (Wenham & Blomberg, 2003:1385). Geldenhuys (2009:328) appears to give the most concise description of 'demon-possession':

In the New Testament demon-possession means that a person is dominated by the spirit of a demon and tormented by him. It is interesting how Luke and the remaining gospels distinguished the case of the "legion" from cases of ordinary sickness, insanity ("lunacy"), leprosy, blindness, lameness, deafness and other natural defects and diseases Matt. 4:23, 24, 8: 6, 10:8; Mark 6:13; Luke 4:40 and 7:21,22.

Accordingly, the event of the demoniac was not merely an ordinary form of mental disease as some writers have alleged, but a special phenomenon, which was particularly frequent during Jesus' earthly experience and thus was directly connected with His coming to destroy the power of darkness.

It is also argued by scholars such as Safrai (1996:17) that unclean spirits were personal beings, which is also evident from what is related about their leaving a possessed person, talking or crying out, possessing knowledge concerning Jesus, as well as other supernatural knowledge that expresses fear (Safrai, 1996:16).

Although demon possession is at times present with some symptoms of schizophrenia such as delusions and hallucinations, there was no evidence to suggest that the possessed man of Gergesene was mentally unwell. Neither is it only a kind of physical disease, although spiritual and physical disease often accompany it (Matt. 7:22, 17:15; Mark 4:18) (Roskam, 2004:100). The individuals at this stage have no control over their own selves but rather are under the influence of a spiritual force.

It is remarkable that Jesus nowhere speaks of forgiveness of sins or of purification-sacrifices that have to be brought after the miraculous curing of such cases (as He did in some cases of physical illness). Those possessed are depicted throughout as unfortunate sufferers, who, by no fault of their own, are dominated by evil spirits and who, when the spirits are cast out by Jesus, accept their deliverance with joy and gratitude (Roskam, 2004:100) (Mark 5:18-20, Luke 8:2).

It is very important that we identify that kind of evil possession described in the Old Testament in 1 Samuel 16: 14 and 1 Kings 22:22, as well as in Daniel 4, and what is described in the New Testament. As already discussed in the case of King Saul, it appeared that it was a mental breakdown following stress, related to the loss of his kingdom to his own servant. The above may be compared to the account in the book of Exodus (Exodus 7:3 and 9:12), where the heart of Pharaoh was hardened and was stubborn even to the point of the death of his own first-born son.

The term ‘demon-possessed’ implies much more than just becoming stubborn and disobedient as in the case of King Saul and Nebuchadnezzar. Possession indicates full and permanent control. Men and women (as well as children) were ‘demonized’ in that they fell under the influence of these unclean spirits. Some appeared not to be oppressed by them so much as exploiting their powers (Acts 16:16), while others were the virtual pawns of these spirits, losing their own identity and autonomy. The person or persons become the mouthpiece or an instrument of the demon (such as Legion, Mark 5:9).[5] Others are absolutely controlled (hooked) by the demon and totally dependent upon it. Kuhn (1999:283) recognizes the military background of the term “legion”, pointing out that in the imperial period a legion consisted of 6,000 foot-soldiers, 120 horsemen and technical personnel. The entrance of the term into colloquial speech indicates that the Roman occupation was a heavy burden. In this context, however, the word “legion” has nothing of the usual Roman military connotation, but is the designation of numerous powers which oppose themselves to Jesus as the embodiment of the power of God (Safrai, 1996:18). According to Kuhn (1999:283), the request by the demons to Jesus to be sent into the herd of swine is found to be the same in the accounts of Matthew, Luke and Mark. The demons being cast out by Jesus, with no other host open to them, implies that they were being sent into the abyss, or bottomless pit, since that remains for them alone.

[5] Demonized individuals are not to be viewed so much as a pigeon-hole category, as they are on a continuum. The spectrum ranges from those who seem to control the demonic powers to those who are utterly controlled by them. The best human analogy might be in the area of drug abuse. Some illicitly use drugs, supposing that they have them completely under their control.

4.8 Conclusion

This chapter focuses on objective 3 of the study. It explores biblical approaches to mental health and their applicability to present day pastoral care. The chapter addresses episodes in the Old and New Testaments, which have been involving what seem to be mental illness and the pastoral care that was given during these times. Pastoral care is well defined, as it is an important component of the discussion. It would appear that Jesus in his ministry also ministered to the outcast and the marginalised, which included people who appeared to be mentally unwell. According to Geoghegan (2011:2), it is quite obvious that Jesus and the apostles lived in a world that took for granted the existence of both good and evil spirits and regularly ascribed mental illness to the malevolent activity of the evil ones. In contrast, fear of demonic influences is notably less obvious in the Old Testament. This may be due to their monotheistic perception that led them to believe that everything came from God, whether good or evil. Saul's insanity is ascribed to "an evil spirit" (1 Samuel 18:10, 19:9), but significantly this is sent "from the Lord", but no mention is made of demons. The text also does not mention that Saul's punishment ascribed to him by disobeying God was a torment of an evil spirit or madness, but rather the loss of his kingship. In view of this, one can conclude, based on the evidence provided in this chapter, that Saul's episode could be ascribed to a mental breakdown, which was in response to all the stresses that appeared to dominate his life at the time and more importantly the loss of his kingship.

Nebuchadnezzar, on the other hand, was described as having a psychotic breakdown (Daniel 4), which had many semblances and characteristics of lycanthropy (the delusion of being a wild animal), a rare dissociative illness that is readily interpreted as a mental disorder by scholars.

Irrespective of whether or not cases similar to that of Nebuchadnezzar can be described as a mental illness, they might well be viewed as opportunities for pastoral care, providing that this is defined as Christian concern for those in physical or mental distress. It can be questioned whether or not they actually received this kind of help or anything corresponding to it, knowing that a great percentage of Christ's time was dedicated to healing the sick. The discussion of mental illness in the Bible is inconclusive and further dimensions could be explored in future studies.

The idea of sickness and recovery in the Old Testament can be traced as far back as Job where sickness appeared to have some association with sin (Job 13:4, 8:1-22 and Deut. 28:39(38-45?). Pastoral care for the ancient Hebrew was more than what is known today. Their role included certification and cleansing of individual in order to be accepted back into communities following certain types of illness, activities or events. They also had the prerogative to declare certain individuals unfit to remain in their communities (Job 13:14). The study established that it has been a common theme in the bible times that all things came from God both good and bad (Job 2:10, Mark 5:26 and Luke 8:43). It is evident that pastoral care in the bible times was tailored to the need of the individual.

The biblical perspective of pastoral care has been explored through this study. Pastoral care in the Bible is said to be the support that is given to a physical person. The Old Testament perspective within the ancient Hebrews was not abstract, general or merely spiritual but a way of life as they gave food for the hungry, welcomed strangers, comforted the bereaved and treated the oppressed with justice.

There is no simple theory of pastoral care in the Old Testament. The goal of care according to the Old Testament is maintenance and restoration of relationship among human beings and between human beings and God, with human relationships appearing to be key in the lives of Old Testament leaders. The prophets in Israel were the mouthpiece of God who communicated His plan. Pastoral care is normally inherent in the messages with God's pronouncement of either punishment for the disobedience and or salvation for obedience.

The Old Testament should never be ignored in reference to pastoral care. God is always active in human life and appoints people to take care of both physical and spiritual needs. God is relational and relates to humans individually, in groups and even as nations. Jesus in the New Testament demonstrated the best possible care. Mark 1: 10-11 discloses the importance of Christ and His approach to meeting the needs of people at their point of need.

The next chapter will explore a practical approach to pastoral care for supporting mental health patients.

CHAPTER 5: FRAMEWORK FOR PASTORAL CARE PROVISION

5.1 Introduction

As discussed in previous chapters, it is believed that pastoral care appears to be a crucial component in the recovery of most health conditions, especially mental health conditions. However, this study establishes that there is minimal provision of pastoral care for mental health patients by Christian churches. It is shown that attention has focused on a humanistic approach to spirituality which eventually leaves God out of pastoral care. A look at the biblical perspective of pastoral care establishes that there are several practical approaches to mental health that can be applied to present day pastoral care. Drawing on the foregoing, this chapter introduces and discusses a framework for pastoral care provision for mental health patients by Christian churches. The framework can serve as a guideline to improve the efficacy and quality of pastoral care provision for mental health patients. The framework is based on Osmer's (2008) paradigm which primarily seeks to equip congregational leaders to engage in practical theological interpretation of episodes, situations, and contexts that confront them in ministry.

Osmer identifies the following approaches that have been followed in the entirety of this research: "the descriptive-empirical," which provides a detailed discussion on the rationale of current involvement in the provision of pastoral care. This study places this discussion in the context of churches and people with mental health conditions. The "interpretive" debate on the differences between religion and spirituality has been explored, as well as the ways in which these differences impinge on the provision of pastoral care for people with mental health conditions. Furthermore, the "normative" approach has been brought to bear on scriptural perspectives of pastoral support for

people who appeared to have mental health conditions in the Bible. There was also a discovery of unequivocal evidence of the development of possible mental health conditions in the Bible, citing examples from the Bible of what should be going on. Finally, having provided this background, practical guidelines for the pastoral care of people with mental health conditions in churches will be proposed. These guidelines will be based on Osmer's pragmatic approach in response to some of the issues raised, and will form the foundation of an action plan.

5.2 Contemporary Issues and Problems with Provision of Pastoral Care

The UK is increasingly a secular society, where God or religion have become uncomfortable subjects to bring into healthcare settings and where people who mention them are likely to be ostracised. Although there is undeniable evidence of the importance of faith in our societies and particularly for the recovery of many health conditions, matters relating to God remain estranged. Zuckerman (2008:18) argues that despite a rampant increase in secularism in countries such as Denmark, Sweden, Norway, and the Netherlands, there is no evidence of social decay, anarchy, or an increase in criminality. By contrast, Zuckerman (2008:18) affirms that "a number of researchers have shown moderately religious Americans report greater subjective well-being and life satisfaction, greater marital satisfaction, better family cohesion, and fewer symptoms of depression than the non-religious communities". Rovers and Kocum (2010:8) state that spiritual care education has not changed much; however, Taylor *et al.* (2009:11) developed and tested a spiritual care course recognising that many nurses and educators do not have training in spiritual care. She stresses the need to continue to educate students with the ability to be therapeutically present, and advocates the weaving of spiritual care training throughout their curriculum. Schulzke (2013:63) has

analysed the ideological dimension of new atheist thought, exploring its links with broader liberal values, which appears to be increasingly influential.

For change to occur in any organisation or institution largely depends on leadership. Church and healthcare leaders require a collaborative approach in order to address these problems by engaging in the active work of saving lives. Marušič and Farmer (2001:196) report that one of the major risk factors for increased suicides in Europe is the perceived absence of God or religion in our societies. Some challenges have been identified by Buse and Hawkes, (2015:11) including the following:

1) Ensuring leadership for inter-sectoral coherence and coordination on the structure of our mental health systems' drivers of mental health services, including social, economic, political, spiritual, and legal;
2) Shifting the focus from treatment to prevention through locally-led politically-smart approaches to a far broader agenda;
3) Identifying effective means to tackle the commercial determinants of ill-health;
4) Further integrating rights-based approaches; and
5) Enhancing a lasting relationship between spiritual health and mental health.

5.3 Leadership and Coordination

This thesis demonstrates that people who have a spiritual dimension in their lives and are in touch with it have a better chance of remaining mentally healthy or recovering quicker should they become unwell. However, it may prove difficult to promote a greater awareness of spirituality in the health service of a secularised society such as the NHS. It would require a strategic approach in delivering, implementing, and establishing a shared value that will be brought in by service providers.

In order for any vision or strategy to become reality, it requires good leadership for implementation. According to Stone, Russell and Patterson (2004) there are two leadership approaches. There is the transformational leader and there is the servant leader, both of which focus on different approaches to achieve their goals. Transformational leaders direct their visions and goals towards organisational change. This style of leadership is about building followers to commit to the organisational objectives. Transformational leaders strengthen the existing vision or build commitment to a new vision of what the organisation could accomplish and become. Friedman and Langbert (2000:81) define the transformational leadership style as that which encourages followers to ignore personal ambitions and interests for the benefit of the organisation. On the other hand, servant leadership is focused on the followers' development, satisfaction and strength. The success of organisational objectives becomes subordinate to the wellbeing of the follower. The primary focus of the leader is to shift the drive from the organisation to the followers. This is usually the unique identifying factor in classifying leaders as either transformational or servant leaders.

According to Van Dierendonck (2011:231), servant leaders empower and develop people as well as expressing humility, authenticity, and interpersonal acceptance. Servant leaders provide direction and take responsibility for the larger organisation (Van Dierendonck & Nuijten, 2011:230), while inspiring followers to deliver their best work-performance by focusing on developing their potential (Van Dierendonck *et al.*, 2014:544). Studies have associated the servant leadership style with work engagement (Van Dierendonck & Nuijten, 2011:233), better life satisfaction, and less burnout among employees (Hakanen & Van Dierendonck, 2013:256), as well as with employees' commitment to change (Kool & Van Dierendonck, 2012:422), trust in leadership (Joseph & Winston, 2005:71), organizational commitment (Bobbio *et al.*,

2012:222) and organisational citizenship behaviour (Walumbwa *et al*., 2010:518). According to Tidyman and Seymour (2004:40), people need to feel comfortable enough to be honest about their opinions, feelings, and possible fears about mental health. This can be achieved by embracing a leadership that promotes inclusion. Tidyman and Seymour (2004:43) explain that many faith communities already welcome, involve, and provide a range of support to people with mental health conditions and their caregivers. They accept the important role they play in enabling people with mental health conditions to be part of the life of the church and the wider community. However, this support does not seem to extend to service users upon admission and general on-going support. This study has established that churches have a role in supporting people with mental health conditions. It is in view of this that a plan is required. For this proposal to be very effective, certain enabling factors need to be in place. These are discussed in the following sub-sections.

5.4 Enabling Factors

5.4.1 Training and Sensitisation

First, church leaders require basic training to enable them to identify and understand mental health conditions and illnesses in their various congregations. Tidyman and Seymour (2004:18) state that faith communities should be places where people feel they belong and where people's mental health needs are recognised and met. They continue to say that people involved in spiritual and pastoral care can play an important role in improving the lives and spiritual well-being of people with mental health needs and may well have mental health needs of their own. As already established in previous chapters, within some church settings, the origins of mental illness are believed to be associated with spiritual activity, particularly the influence of demonic forces. It can at times be

very difficult to differentiate between demon possession and the emergence of mental health conditions. For instance, from Mark 5:1-21 and Luke 8:26-41, there is the example of a man who presented with symptoms of severe self-harming behaviour. As a result, people have made the false assumption that negative emotional symptoms are simply the result of demonic activity (Pozner, 2013:1). The interviewed church leaders all expressed a wish to tackle the lack of knowledge and understanding about mental health issues. Especially, those with life experience of mental health conditions recalled many stories of patients being blamed, being told that their problems were due to a lack of faith or to not worshipping enthusiastically. The church leaders agreed that the church should work collaboratively to provide mental health awareness training at local levels.

This collaborative awareness training can be done by inviting the local mental health service to give presentations about mental health or to attend locally organised events and also to support the expertise that already exists in church communities, including those with life experience of mental health difficulties. This would help increase awareness, and hopefully acceptance about mental illnesses.

It is important to note that the church is not here to take the place of professionals; the church should not be the doctor, psychiatrist, or chemist. Sometimes counselling can be used to support people, but not necessarily in place of a professional counsellor or psychologist.

It has been recommended that mental health services build effective links with faith communities and address spiritual needs in order to deliver effective care (Cornah, 2006:16; Coyte *et al.*, 2008:21; Saxena *et al.*, 2007:879). Worthington *et al.* (1996:96)

speculate that changes in the healthcare system in the USA might lead to more people seeking counselling from the voluntary sector and clergy. Although contexts differ between the USA and the UK, the current political and financial atmosphere suggests that a similar shift in the pattern of seeking help may emerge in the UK (Evans 2016:12). The importance of MH and collaboration with health services is also reflected in the documentation produced for the church (Tidyman & Seymour, 2004:17). Research has shown that there have been few studies within the UK exploring the practices and experiences of clergy/church leaders in relation to mental health. More research has been conducted in the USA (McMinn *et al*., 1998:569; Worthington *et al*., 1996:84), which found that referrals tended to be uni-directional from clergy to mental health professionals (MHPs), and that clergy were more likely to refer if they knew that MHPs shared their beliefs and values. However, there has not been any evidence of the MHPs referring to the clergy.

5.4.2 Congregational Cohesion

According to the interviewed church leaders, some of their churches have visitation teams that visit hospitals and nursing homes. However, there was no mention of these visits including psychiatric hospitals. Churches appear to have no formal support plans for people with mental health conditions. The church and the healthcare practitioners need to be co-workers with Christ. A comment from one church member: “I left this church because of the way they treated a member with mental health conditions and a history of assault. He was expected to come after service on his own or to stay home and be sent a recorded version of the service. I was horrified.”

As Ellen White once wrote:

The Saviour ministered to both the soul and the body. The gospel which He taught was a message of spiritual life and of physical restoration. Deliverance from sin and the healing of disease were linked together. The same ministry is committed to the Christian physician. He is to unite with Christ in relieving both the physical and spiritual needs of his fellow men. He is to be to the sick, a messenger of mercy, bringing to them a remedy for the diseased body and for the sin-sick soul (White, 2006:112).

The church should offer a radical hospitality, hope, and family to those who are often marginalised and stigmatised, just as Jesus modelled. However, this was not found, as members have no or little knowledge of how to support people with mental health conditions, including those with a related criminal conviction.

The interviews conducted for this study revealed that at times churches find it very difficult to refer mental health cases to mental health practitioners, to engage in relationships, and to manage people with mental health conditions. The need for more inter-professional teamwork between clergy and mental health practitioners has been highlighted by Leavey *et al.*, (2007:548). It is, however, important to note that the church has no professional responsibilities towards the sick, but they do have a responsibility to be by their side.

Again, White writes:

The Saviour in His miracles revealed the power that is continually at work in man's behalf, to sustain and to heal him. Through the agencies of nature, God is working, day by day, hour by hour, moment by moment, to keep us alive, to build up and restore us. When any part of the body sustains an injury, a healing process is at once begun; nature's agencies are set at work to restore soundness. But the power working through

these agencies is the power of God. All life-giving power is from Him. When one recovers from disease, it is God who restores him (White, 2006:113).

5.4.3 Small Groups

In an attempt to reduce the marginalisation of the sick and people with social problems, small groups, cell groups, or house groups are identified as models not only to help resolve discrimination in the church, but also to meet the needs of marginalised individuals on a personal level.

The Apostle Paul explains why the church should be the place of transformation in 2 Corinthians 5:17. “If anyone is in Christ, he is a new creation; old things have passed away.” However, despite this, the church seems to miss this important part of their calling. Churches need to make the house of God a place of transformation and change, a place of solace and safety.

A research project conducted by Stetzer and Geiger (2014:3) reveals that almost 79 percent of those surveyed agreed that small “transformational groups” are very important in the church; about two-thirds of the respondents said that their church regularly starts new small groups that are usually based on geographical locations. This appears to be one way of breaking relational barriers.

5.4.4 Shifting the Focus

It is quite evident that both the current governmental education system and the health system may be failing to deliver on health policies that claim to focus on prevention and early intervention in the UK. The Book of Proverbs 22:6 talks about training our children the way they should go during their early years, which illustrates a grassroots

approach. An example of a popular proverb that is not from the Bible and that we use today is, "An apple a day keeps the doctor away." Of course, when we repeat this proverb we do not actually believe that eating an apple every day guarantees excellent health. But we do believe that, in general, healthy eating contributes to excellent physical health. The Bible gives guidance on matters pertaining to our salvation Proverbs contains general truths for development.

There are instances where parents seemingly have worked as hard as stated in Proverbs 22:6, which implies that parents may achieve a godly lifestyle for their children by working hard to train them in godly ways; this does not always work according to plan, but the likelihood is always high. Gunnoe and Moore (2002:4) explain that the phrase "to train up a child in the way he should go" in the context of Proverbs denotes the parental responsibility for giving dedicated time to teaching their children. This does not only apply to religious values, but also to health values. The UK education system does not currently include general health education that is dedicated to instilling health values in children from a very early age.

In the UK, the aspiration is that children excel in Maths and English. However, there is no emphasis to train them to be the best in maintaining control over their health. A study conducted by Lister Sharp *et al.* (1999:5) about health promotion in schools shows that health-promoting schools saw a significant reduction in sexual health issues, in child pregnancy and in substance abuse, as well as improvement in physical health, personal hygiene, and many other health related areas. It is highly important that the church, the health services, and the educational systems work alongside each other to reduce the endemic mental health conditions.

5.5 Conclusion

One practical way to improve the efficacy and quality of pastoral care is by devising and implementing a standard framework that can guide churches and ministers in their pastoral care approach.

The focus of this chapter is to propose one such framework. The chapter addresses the last objective of the study which is to propose a framework to improve the efficacy and quality of pastoral care provision in mental health.

Pastoral care has been identified and maintained as a crucial component of recovery for people with mental health conditions. A frame work is formulated, based on Osmer's 2008 paradigm of pastoral care, in an attempt to motivate local ministers and health care staff to adopt and to help improve the provision of pastoral care to local congregations, especially people with mental health conditions.

The study identified that despite evidence suggesting that pastoral care provision improves various health conditions, especially mental health, there appear to be factors such as lack of relationship between health sectors, the emergence of secularism, poor educational curricula in basic schools and lack of appropriate training for health care workers.

A framework has been developed to serve as a guide for the provision of pastoral care.

Training and sensitization:

Provision of training for church leaders and congregations is found to reduce the stigma attached to some mental health conditions and to provide opportunity for congregations to understand and accept how to manage mental health conditions.

Congregational cohesion:

Loving relationship appears to be a tool that may enhance the provision of pastoral care if there is togetherness and oneness in goals.

Small groups:

The study suggests that pastoral care on a small scale or a one-on-one basis is more effective and also helps to reduce stigma and improve cohesion.

Shift the focus:

All the above will only be effective if there is a change in focus. There is need for the health services and the churches to focus more on prevention and for making provision for implementation.

CHAPTER 6: RECOMMENDATIONS

Having assessed the collected data, reviewed the literature and drawn conclusions from each of the study objectives, the following recommendations are proposed.

1. It is recommended that the church should partner with their local mental health services to offer pastoral, spiritual or religious care support on a voluntary basis. This partnership can improve the relationship between communities and hospitals in order to reduce stress on the healthcare service workers. This will also bring a change in perception and in the nature of a community's involvement in delivering support to people who are in dire need of it. It will, therefore, mean that the church can respond to calls of increasing complexity without fear of stigma. The diversity of religions, beliefs, and cultures within the population has grown and the need for pastoral care is invaluable.
2. It is crucial that the leadership of local congregations can see the need and the importance of pastoral care for those of our congregations with mental health needs who require support and love.
3. It will also be immensely helpful to the health service for congregational leaders to make financial provision to support members who are interested in ministering to people with mental health conditions both in and outside the church.
4. In addition to the financial support, members will understand mental health conditions better and also reduce the stigma if regular training is provided by qualified mental health practitioners.

   The church is integral when deciding on a strategic approach in the delivery of this all-important ministry.

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ANNEXURE A

Mental health and pastoral care for church leaders: questionnaire

Please help improve the relationship between the church and the Psychiatric Hospitals by completing this questionnaire. All responses will be treated in utmost confidence. Interview Protocol: Perspectives on Mental Health and Spirituality.

1. Definition: (Descriptive)

i. What is your understanding of mental illness?
ii. Can you describe how you first became aware of Mental Health in your Church?
iii. Describe your understanding of pastoral care.
iv. Describe how people with me.ntal conditions fit into your Church culture.

2. Frequency: (Interpretive)

i. How often do you see members of your Church visit you in hospital?
ii. How often do you visit members of your Church in hospital?

3. **Purpose:** (Interpretive)

i. Why the need for pastoral care?
ii. How does your understanding of religion and spirituality impinge on the provision of pastoral care?

4. **Content:**

i. To what extent at present is provision being made by Southampton churches for the pastoral care of mental health inpatients in psychiatric hospitals?

5. **Content:**

i. How can a practical way be devised to provide pastoral care for people with mental health needs?
ii. What does pastoral care mean to you?

6**. Content:**

i. To what extent would you consider people with mental health conditions to actively involved in the daily running of your church?
ii. What support plans does the pastoral care team in your church have in place for people with mental conditions?

From Janesick, V. (1998), "Stretching" exercises for qualitative researchers (Thousand Oaks, CA: Sage, p. 75).

Annexure B

Mental health and pastoral care for inpatients questionnaire

Please help improve the relationship between the church and the Psychiatric Hospitals by completing this questionnaire. All responses will be treated in utmost confidence.

Interview Protocol: Perspectives on Mental Health and Spirituality

1. **Definition:** (Descriptive)

    i. Describe your understanding of pastoral care

2. **Frequency:** (Interpretive)

    i. How often do you see members of your Church visit you in hospital?

3. Purpose: (Interpretive)

    i. Why the need for pastoral care?

4. **Content**:

    i. Do you currently receive any pastoral care whether in hospital or in the community as a mental health patient?

5. **Content**:

    i. What does pastoral care mean to you?

6. **Content:**

    i. What support plans does your church have in place for you?

From Janesick, V. (1998), "Stretching" exercises for qualitative researchers (Thousand Oaks, CA: Sage, p. 75).

Annexure C

Mental health and pastoral care for healthcare practitioner questionnaire

Please help improve the relationship between the Church and the Psychiatric Hospitals by completing this questionnaire. All responses will be treated in utmost confidence. Interview Protocol: Perspectives on Mental Health and Spirituality

1. **Definition**: (Descriptive)

    i. Describe your understanding of pastoral care.

2. **Frequency**: (Interpretive)

    i. How can the church be involved in improving pastoral care for psychiatric patients?

3. **Purpose**: (Interpretive)

    i. What are the probable challenges to provision of pastoral care to people with mental health conditions?
    ii. How does your understanding of religion and spirituality affect provision of pastoral care?

4. **Content**:

    i. To what extent are you willing to work with churches to improve pastoral care of mental health inpatients?

5. **Content**:

    i. How can a practical way be devised to provide pastoral care for people with mental health conditions?

5. **Content**:

    i. What support plans would you put in place for churches to facilitate pastoral care to people with mental health conditions?

From Janesick, V. (1998), "Stretching" exercises for qualitative researchers (Thousand Oaks, CA: Sage, p. 75).

Annexure D

Module 2.1_Training_ Certificate.pdf

Module 1_Training_ Certificate.pdf