Church leader's understandings of how Christian beliefs inform mental illness identification and remediation in effected members: A scoping review

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Declaration

I, Lethukuthula Nkanyiso Nhlumayo (218054089), hereby declare that the work of the following Dissertation with the title: CHURCH LEADER'S UNDERSTANDINGS OF HOW CHRISTIAN BELIEFS INFORM MENTAL ILLNESS IDENTIFICATION AND REMEDIATION IN EFFECTED MEMBERS: A SCOPING REVIEW

was solely undertaken by myself, with no help from sources other than those allowed. All sections of the paper that use quotes or describe an argument or concept developed by another author have been referenced, including all secondary literature used, to show that this material has been adopted to support my dissertation. This dissertation has not been previously submitted for assessment to another institution or for another qualification.

Date: 18/12/2021 Signature: 

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We did it!

Abstract

Introduction: Christianity is the world's leading religion with an estimated 2.3 billion followers, with evidence of influence both in the developing world and amongst developed nations throughout the globe. Literature has demonstrated that church clergy across varying contexts and communities serve the function of mental health gatekeepers and are often the first access point for their community, particularly among people living in low socio-economic settings without adequate access to professional mental health services. However, some issues raised by previous studies were that certain Christian beliefs have been linked with promoting stigma, internalized shame and delayed help-seeking. This study aims to synthesize and map past research that investigated church leader's representation of how Christian beliefs inform mental illness identification and remediation (referral pathways) in vulnerable church members. **Method and Analysis:** A scoping review was performed to gain an overview of the available evidence from literature concerning this topic. The data was screened using the PRISMA-ScR flow diagram according to the inclusion and exclusion criteria. Relevant databases were sourced for literature and a total of 11 studies were eligible for final review. **Results and Discussion:** Data from the literature was synthesized in table format according to: Author(s) and Year, Study Title, Aims and Objectives, Operational Definition of Concepts, Methodology, and Results. Thematic analysis was used on the data to describe the existing literature and gaps in narrative format. Four themes were identified from the data; 1) Clergy's conceptualisation of mental illness, 2) Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways) 3) Impact of socio-cultural context, 4) Reviewed Study's Recommendation. These themes were found to be prominent dynamics among studies that investigated clergy's representation and treatment of mental illness. **Conclusion and Recommendations:** Four overarching themes were identified among studies that investigated church clergy's representation and remediation pathways of mental illness for

vulnerable church members. Future research should focus on researching the usefulness of clergy and mental health practitioner collaborations in mental health treatment, which can benefit vulnerable church members.

Keywords: Church leader's, Clergy, Christianity, Christian beliefs, Community Health Workers, Mental health, Remediation, Mental illness

Contents

Chapter 1: Introduction

1.1 Background and rationale for this study

The estimated worldwide Christian population is numbered at 2.38 billion which accounts for just over a third (31.1 %) of the world's population, thus representing the most widely followed religion in modern times (Hacket & McCledon, 2015). Christianity has been highly influential across various societies and cultures, it has had significant influence in the: 1) development of social norms and moral standards that transcends history; 2) the establishment institutional places of worship integral to communities across different geographic locations (Pillay, 2017). Christianity is a religious worldview that purports a comprehensive explanation of the world and existence, it provides its constituents a moral framework that shapes how Christians are to engage with life (Woodberry, 2012). Christianity and the various sects are important community institutions which serve the purpose of fostering community care and beneficence (Wesselmann et al., 2015).

It is estimated that 10 percent of the world's population is impacted by mental health related issues (Roser & Ritchie, 2018). Mentally illness present presents patients and their immediate social support with a variety of challenges, some of which may lead to adverse psychosocial experiences (within families and communities) (Wainberg et al., 2017). People who live in low socio-economic settings are the most affected by mental health issues, which has reciprocal impacts on health, development, and socio-economic standing (Saraceno & Saxena, 2002). Mental health care institutions are integral services which exist to help mitigate the impacts of mental illness (Jacobs et al., 2015). However, formal health care services are not widely accessible or cost efficient for mental health care users (MHCU) particularly for people of a low socio-economic background. The majority of the world's mentally ill population are adversely impacted by poverty resulting in limited access to appropriate mental health care

(Saraceno & Saxena, 2002). Docrat et al. (2019) state that in South Africa, the provision of mental health services is limited by a lack of human resources, infrastructure, and adequate psychiatric medication. The lack of adequate mental health care services is one of the reasons community health workers such as faith and spiritual healers are popular in low-to-middle income countries (Rathod et al., 2017).

Traditional and spiritual health care practices have their roots embedded in cultural norms, beliefs and practices in societies throughout the world. Historical accounts of early civilizations have identified a distinct link between cultural conceptualizations of well-being or ill-health to alternate forms of care (non-medical) (Sorsdahl et al., 2009). Community health workers (CHW) are also integral health care providers within communities as they are accessible and make use of culturally accepted means of care that resonate with community members' beliefs and way of life (Sorsdahl et al., 2009). Unlike formal mental health services, CHW may provide health care services to community members from spiritual/religious backgrounds that are shared within a community (Sorsdahl et al., 2009). CHW such as church and spiritual leaders often appeal to the cultural and/or religious beliefs within their community, this can have an impact on the help-seeking behaviour of community members and can at times delay recovery (Rathod et al., 2017). Within the Christian community, pastors and church leaders of various sorts play the role of CHW in varying capacities. It has been seen that vulnerable church members are most likely to first access church leaders for mental health related issues (Heseltine-Carp & Hoskins, 2020). This suggests that churches and church leaders play an important role as mental health gate keepers for their communities (Bledsoe et al., 2013).

Christianity and mental illness share a complex history with both positive and negative interactions. Mental illness within Christian communities has been historically understood as

a spiritual issue and linked specifically to demonic possession or moral failure (Standford & McAlister, 2008). This has been a contentious belief and has been linked with mental health stigma and shames individuals for their mental health issues (Wesselmann and Graziano, 2010). In contrast, Christian communities historically have offered care and safe spaces for people with mental illness through their ministries. Cook (2020a) highlights that the bible narrative suggests that Jesus was caring of individuals with mental illness. It has been noted that some church leaders are accepting of clinically based understandings and treatment of mental illness (Stanford, 2007). The church and church leaders can be influential in communities and their health behaviour (Heward-Mills et al., 2018). Apart from healthcare practitioners, church leaders are considered to be influential in how communities think, feel and act about health matters (Anshel & Smith, 2014).

Behere (2013) states that Christian communities can prove positive influences on the mental health of congregants as they provide social support and promote positive coping skills. Adams et al. (2018) suggest that Christian beliefs can have a profound impact on how mental illness is interpreted and addressed within a Christian community. Among Christians there have been varying responses to help seeking behaviour, across various contexts Christian accept or reject medical based care of mental illness (Almanzar, 2017). Attitudes toward health and mental illness in the church has been mainly influenced by how biblical doctrines are interpreted and understood (Almanzar, 2017). Christian based approaches towards mental illness can have an impact on the treatment of vulnerable church members (Adams et al., 2018). Christianity's conceptualisation of mental illness has contributed towards stigma against mental illness (Mathison & Wade, 2014). This places an emphasis on the importance of understanding the Christian model of mental illness as this has far-reaching implications on how many communities approach mental health.

The perceptions church leaders/representatives hold about mental illness are important as they provide references for church members that influence how the perceive of mental illness (Oppenheimer et al., 2008). There has been a paucity of studies which have focused on investigating the influence of church leader's perceptions of mental illness according to Christian beliefs and their treatment/referral actions (Adams et al., 2018). By investigating the broad literature on this topic, the study will be able to synthesize and collate data which can foster understanding around concepts and themes pertaining to Christianity, mental illness and how church leaders approach treatment. This study can offer valuable information on how church leaders and Christianity around the world understand and engage with mental illness, which can also reflect the experiences of people living with mental illness who are affiliated with Christianity.

1.2. Operational definitions

1.2.1 Church leader/Clergy/Pastor

In the Christian tradition, church leaders are persons ordained to provide guidance on religious living and worship, and facilitate sacraments and rites of passage (Tamunomiebi, Omosioni, & Odunayo, 2018). Church leadership roles and functions vary according to titles, divine allocation, denominational structures, experience and sometimes gender (Church, 2014). Leaders in the church hold certain authority over various church structures and the congregational body, they effect regulations and reinforce the religious beliefs subscribed to be the church organisation (Church, 2014). Among church leaders, pastors may possess more significant role in church structures and activities. Pastors are a churches main spiritual guide, they accomplish this by disseminating and upholding spiritual teachings, and initiating the spiritual and social activities executed by the church (Chimoga, 2019).

1.2.2. Christian beliefs

Christian beliefs are centred around the Judeo-Christian religion which draw their foundations on the person of Jesus Christ, who is deemed the central and defining figure of Christianity (Baham, 2020). The Bible is seen as the document that gives followers of Christianity their body of beliefs, which is touted to encompass comprehensive moral guidance, explanations on human behaviour and the nature of reality, and predictions of future events (Baham, 2020; Hedrick, 2008). Christian beliefs are mainly founded on Old-testament scriptures which are shared with other Abrahamic religions and the New-testament which contain teachings from Jesus, narratives of his life and teachings from his earliest most prominent disciples (Hedrick, 2008; Gooding & Lennox, 1997). This provides a tentative definition of broad Christian beliefs yet is not inclusive of other specific beliefs that vary across Christian denominations.

1.2.3. Mental illness

Mental illness broadly defined is characterised by a range of brain diseases and patterns of maladaptive behaviour which hamper a person's ability to adequately at a cognitive and social level (Hyman et al., 2006). Mental illness can be understood as mental distress which can be marked by various symptoms that can contain depressive and anxiety symptoms often linked to specific stressors (Viertiö et al., 2020). Depressive and anxiety disorders are considered as common mental disorders due to their high prevalence and comorbidity with other mental health issues, these disorders are commonplace in primary and community mental healthcare centres (Risal, 2011). The study will focus the research on mental illness broadly defined, mental distress, depression and anxiety, and disregard other specific mental illnesses.

1.3. Aims and Objectives

- To explore existing evidence of church leaders' perceptions of mental illness

- To explore and understand how Christian beliefs inform perceptions of mental illness and their role in remediation and treatment

- To identify preferred intervention/referral pathways (i.e., religious and/or mental health professionals)

Chapter 2: Literature Review

2.1. Introduction

The current chapter will be a review of literature on various frameworks that provide knowledge of mental illness, Christian beliefs, church clergy's attitude towards mental illness. Included in this chapter is a broad scope on literature regarding church clergy's representation and treatment of mental illness and will finally conclude with the rationale for the current research. To adequately contextualise the research topic, this chapter will contain a review of existing explanatory models of mental illness (this will include explanatory models from the following fields of research (biomedicine, psychology, cultural anthropology and religion), Christian beliefs and their relation to mental health issues, and the role of clergy in mental health care and treatment. A further aim of this review is to provide insights into the perceived impact church clergy have on congregant's experiences of mental health challenges. This area of study has not been widely researched and the current study aims to identify gaps in the literature.

Mental illness has become recognized across the globe as the leading cause of disability (Wainberg et al., 2017). Roser and Ritchie (2018) estimate that more than 10% of the world's population are living with mental health related issues. Among the population of people living with mental illness, 80% live in low-to-middle income countries (Javed et al., 2021). In various countries across the globe mental health care services have been limited by shortage in mental health care practitioners, lack of adequate inclusion in health policy, and mental health stigma (Wainberg et al., 2017). In low-to-middle income countries the prevalence of mental health related issues impacts negatively on people's quality of life and on the overall economic burden (Rathod et al., 2017). The shortage of adequate mental health services is known as the 'mental

health treatment gap' where the provision of treatment does not satisfy mental healthcare needs, which is commonly experienced in low-to-middle income countries (Qin & Hsieh, 2020).

Current mental healthcare treatments often involve psychotherapy, psychiatric medication, and various psychosocial interventions which can be accessed from both formal and private health care services. Contemporary understandings of mental illness are mainly influenced by Western Biomedical and Psychiatric Models which underlie the treatment options provided by formal health services (Benning, 2015). However, beliefs and ideas (which inform meaning) about mental illness in different communities and cultures are varied and contested. There are many culture-specific explanations of mental illness which influence commonly held understandings about mental illness in terms of its origin and treatment (Choudry et al., 2016; U.S. Department of Health and Human Services, 2001). Culture plays an important role in how mental illness is understood and managed by mental health care users and practitioners (U.S. Department of Health and Human Services, 2001). The concept of culture entails multidimensional facets of socializing factors such as common beliefs, gender, religion, language and class (Gopalkrishnan, 2018). The field of psychiatry and psychology has been largely influenced by Western Models of mental illness (origin & cause-effect pathways), evidenced by current clinical practice (Njenga, 2007; Gopalkrishnan, 2018).

2.2. Western Models on mental illness

Mental health in Western society has been predominantly influenced by scientific inquiry and Western medicine (U.S. Department of Health and Human Services, 2001). Mental illness is understood according to medical understandings of psychopathology where the focus is on physio-biological structures that may be functioning irregularly/abnormally (Jacobs et al., 2015). According to the Western model/Biomedical Model, observable maladaptive behavior marks the presence of psychopathology, this maladaptive behaviour is seen as impairing to the

individual and those around them (Jacobs et al., 2015). Mental illness is viewed similarly to physical illness as treatment is designed to focus on biological processes, cognitive processes and behavioural outcomes (Jacobs et al., 2015). Western models of mental illness follow Eurocentric frameworks and rely on science based medical treatment (Ingle, 2018).

Western beliefs about mental illness are influenced by the evolutionary perspective. Evolutionary theory places emphasis on the impact of ecological and social factors which can influence the presence mental disorders (Durisko et al., 2016). Biological processes such as genetic predispositions and heritability are considered as important factors that can underlie the presence of mental illness (Durisko et al., 2016). Evolutionary theory has provided helpful insight on tracing mental illness according to heritability, this has informed mental health research and diagnostic organization of mental disorders. In recent times, mental illness has been conceptualised more broadly from the traditional Western Biomedical Model to the Biopsychosocial Model (Engel, 1977, see section 2.3). The Biopsychosocial Model advanced modern health care (i.e., influenced assessment, diagnoses & intervention) by incorporating the impact of various environmental factors (Durisko et al., 2016).

Treatment of mental illness from a Western Model primarily involves the use of psychiatric medication and psychotherapy. Psychiatric services are a popular treatment option for mental illness and are seen as the most scientific treatment methods of mental illness (Jacobs et al., 2015). Psychotherapy focuses on the treatment of mental illness by focusing on an individual's thoughts, emotions, attachments and social factors which may influence maladaptive behavior. The Western Model is mainly individually focused, and treatment is primarily focused on agentic functioning (Treadinnick & Fowers, 2007). However, Western Models have been critiqued for its individualistic and myopic approach towards mental illness and broader socio-cultural factors.

Western models of mental illness can be restrictive and undervalue the role of culture when attributing the influence of causal factors of mental illness (Jacobs et al., 2015). The Western approach, which is based on scientific inquiry, dichotomises 'normal' and 'abnormal' behavior, and treatment involves making 'ill' people 'healthy' (McCan, 2016). However, this view of mental health ignores culturally laden mental illness symptomology that require culture-specific mental illness formulation and treatment (McCan, 2016). Models of mental illness need to have a perspective that considers the influences of family, culture, spirituality and social contexts from which mental illness exist in, the Biopsychosocial Model is such an approach (Ghaemi, 2009).

2.3. Biopsychosocial Model of mental illness

The Biopsychosocial Model has become the generic approach towards mental illness in contemporary psychology and psychiatry as in other health disciplines (Ghaemi, 2009). George Engel is considered the founder of the Biopsychosocial Model and believed that scientific inquiry should be inclusive of systematic understandings of mental illness (Pilgrim, 2002). Engels saw mental illness as comprising various physical elements ranging from sub-personal (cortical, biological, medical) to supra-personal (two-person, family, societal) elements that create a mental illness nexus (Pilgrim, 2002). The Biopsychosocial Model is considered as a more wholistic approach than the Biomedical approach which is considered to be reductionistic in its formulation of mental illness (Ghaemi, 2009).

Unlike the Biomedical Model, the Biopsychosocial Model is able to understand the presence of mental illness without assuming an existing pathology (Wade & Halligan, 2017). The Biopsychosocial Model does not exclude the Biomedical Model; however it views biomedical components as part of other processes in the development of mental illness (Wade & Halligan, 2017). The presence of mental illness for differing patients cannot be viewed from

a unipolar perspective, however each patient presents with an idiosyncratic context that needs to be given specific consideration (Tripathi et al., 2019). According to the Biopsychosocial Model, recovery from mental health related disorders is possible from multiple resources that have specific meaning to the patient's context (Wade & Halligan, 2017).

The presence of the Biopsychosocial Model of mental illness has benefitted the treatment of mental health on various levels. The Biopsychosocial Model inspired the multidisciplinary approach towards mental health treatment, which has become fundamental in mental health patient care (Havelka et al., 2009). The multidisciplinary approach has influenced various disciplines to glean from each other and refurbish already existing approaches towards mental health care (Havelka et al., 2009). Also, the Biopsychosocial Model of mental health has provided an approach which can appreciate more nuanced factors in mental illness (Babalola et al., 2017).

The application of the Biopsychosocial Model requires the consideration of multiple factors that may not always be available in clinical settings, particularly public healthcare services (Babalola et al., 2017). The Biopsychosocial Model has been critiqued because of its holistic approach which does not delineate guidelines on which factors are most important in treating mental illness (Babalola et al., 2017). Even though the Biopsychosocial Model provides a broader outlook than the biomedical approach it is limited in considering human subjectivity (Benning, 2015). Benning (2015) states that the biopsychosocial perspective is limited in its appreciation of subjective factors such as culture, spirituality and personal meaning, it has difficulty integrating these factors into its model.

2.4. Cultural perspectives of mental illness

Culture is a broad-band term that encompasses various factors of social experiencing such as gender, race, ethnicity, class, religion, language and nationality (Patterson, 2014).

‘Culture’ provides people groups with lenses to approach life tasks and experiences, this fosters the development of specific beliefs and outlook (Patterson, 2014). Understandings and treatment of mental illness have varied across cultural groups and are specific to widely held beliefs within a community (Dalky, 2012). Cultural perspectives have implications on how mental illness is perceived by the patient and their societal context.

Christianity, from its advent in Jewish middle east to its current global reach, has had complex interactions with various cultures and peoples throughout its history (O’Callaghan, 2017). Christianity is not in itself a specific culture but it has always been communicated and influential through a cultural framework, this is exemplified through socio-political campaigns such as Roman imperialism and western colonialism that went in-hand with Christianity’s influence on social life across the globe (Mugambi, 2005; O’Callaghan, 2017). During the advent of Roman Catholicism, the church and its doctrines were threaded into the socio-political life of Rome and its subsidiaries, to the extent where Roman citizenship presupposed allegiance with the Catholic church (Mugambi, 2005). Colonialism saw the spread of western Christianity, this was not only achieved through missionary efforts, but the church was part of the socialization process that promoted western modernity and thinking through faculties such as education, politics, health etc., (Mugambi, 2005; Schmidt, 2015). However, Christianity’s expansion during these times had direct impacts on indigenous cultures, which were labelled as ‘uncivilized’ and ‘ungodly’, and also set a president for Christianity’s hegemony in colonised regions (Nkomazana & Setume, 2016). Even in ‘post-colonial’ times Christianity has remained influential alongside the expansion of western ideology and globalization. Regardless of its hegemony, Christianity itself has been adapted and reinterpreted by indigenous people and cultures in an aim to use the religion in a manner that best fits indigenous spirituality (Schmidt, 2015). In Africa, it is not uncommon to find Christianity practiced alongside indigenous religions that have resulted in distinct African indigenous Christianity,

with the Zionist and Shembe church in Southern Africa as examples of churches that insist on combining both spiritualities. Christianity's influence on contemporary society should not be seen as a monolithic voice, however, its influence lies in its collision and adaptation with different peoples, cultures, and religions (Schmidt, 2015). In any attempt to understand Christianity's role in shaping perceptions of mental illness, there needs to be an appreciation of its unique engagement with culture and cultural identities.

In the clinical setting, patients often present with mental illness according to how their culture shapes the phenomenology of mental illness (U.S. Department of Health and Human Services, 2001). On a broader level, culture shapes help-seeking behaviour, coping mechanisms and social support, as culture provides agents with frameworks to approach mental illness (U.S. Department of Health and Human Services, 2001). These factors impact on how mental health issues are communicated and valued within a specific culture. Therefore, to adequately understanding how mental illness is understood amongst mental health care users, it is important to engage with their cultural perspective and their nuances.

A significant number of people in South Africa subscribe to and practice traditional African beliefs. Traditional healers and spiritual leaders are integral in providing mental health care needs as they offer culturally appropriate treatment which coincides with the beliefs of many South Africans (Sorsdahl et al., 2009). African traditional beliefs stem from the foundational belief that corporeal and incorporeal entities can't be separated and are able to act on each other simultaneously, and harmony between the spiritual and physical entities needs to be maintained (Barlow & Durand, 2005; White, 2015). These entities can be understood to be God, ancestors, spirits/demons, and strongholds specific to an area (rivers, sea, forests) (Barlow & Durand, 2005). According to African beliefs there exists a continuity between

tangible and spiritual experiences and both ‘realms’ must be given homage as they continue to play an important role within the community (Kruger, 2012).

Ancestral spirits are recognized as a part of the family or community and are often considered during rites of passage, thanksgiving, important family decisions or the resolution of a dilemma (Franklin et al., 1996). According to African traditional beliefs, mental illness can be viewed as punishment from ancestors, and the treatment of the mental illness would be through appeasing ancestors (Franklin et al., 1996). Mental illness can appear due to witchcraft and/or demon possession where the presence of evil spirits can undermine a person’s mental state (Van Niekerk & Prins, 2001). Illness or difficulties that result from bewitchment are seen to be incurable by Western treatment however bewitchment must be reversed through divination and African traditional medicine (White, 2015). Traditional healers play an important role in African communities as they are seen as gifted individuals who can reverse spells and invoke an intervention between the living and their ancestors to foster healing (Zabow, 2007).

Within indigenous African beliefs, traditional healers are considered the main health practitioners and dispense treatment or spiritual modes of intervention, traditional healers can include diviners and herbalists (Sorsdahl et al., 2009; Zabow, 2007). Diviners are individuals with special abilities in understanding how spiritual entities impact on the presence of illness (Sorsdahl et al., 2009). In South Africa, many people will consult traditional healers and spiritual leaders for mental health related difficulties prior to seeking medical attention (Sorsdahl et al., 2009). Traditional healers and spiritual leaders are the preferred source of treatment as they offer culturally appropriate treatment which fit the cultural contexts for many South Africans (Sorsdahl et al., 2009).

2.5. Religious perspectives on mental illness

Religion can be understood as devotion to an object that is deemed sacred and are to be worshipped (Koenig, 2009). Religious affiliation involves the acceptance of beliefs, rituals, moral code and societal norms that reflect devotion to a supernatural being (Newman, 2004). Religion and spirituality are often understood to be interchangeable terms that reflect similar concepts, however contemporary views on religion and spirituality understand these to explain differing modes of engagement with deity (Koenig, 2009). The concept of spirituality is debated; however, it can be understood as the exploration of existential issues that are referenced from beliefs in supernatural/immaterial beings (Moreira-Almeida et al., 2014). Spirituality can hold a more subjective meaning at a personal level and can include notions of positive psychology (Moreira-Almeida et al., 2014). Despite the difference in meaning religiosity and spirituality have coincided for much of human existence and form integral parts of community life.

Religion and spirituality date as far back as the beginning of written history and have metamorphosized since primitive ages until modern times (Behere et al., 2013). Religion and spirituality have provided various societies with models of meaning making, and sustain ideas and traditions that form structural basis for various societies (Behere et al., 2013). Religions take the shape of worldviews which aim to offer comprehensive explanations of existence and human experiences.

Mental health and religion share a complex history which have provided contrasts in how health care issues are approached, the history between mental health and religion/spirituality is complex and contested (Moreira-Almeida et al., 2014). Many of the first psychiatric institutions were run by ministers and located in churches, and these institutions were seen to provide compassionate care where state run institutions were inadequate (Koenig,

2009). However religious communities and various religious beliefs have influenced the presence of stigma, shame and other negative connotations around mental health (Wesselmann et al., 2015). The complex relationship that exists between mental health and religion has impact on how religious/spiritual communities' approach mental health care treatment. To understand this relationship, it is helpful to understand how religious and spiritual people explain mental illness.

Within the plurality of religions around the world there are many explanations of mental illness. Explanations of mental illness vary across ideas about punishment for sin/moral failure, possession from unbenign spirits, impaired faith, or unobserved rituals/rites (Moreira-Almeida et al., 2014; Stanford, 2007; Okasha & Okasha, 2012). Wesselmann and Graziano (2010) found that within Christianity two prominent beliefs about the origins of mental illness are widely accepted; that mental illness emanates from sin/moral failure or the influence of spiritual forces. In ancient times religious explanations of mental illness were prominent and widely accepted and often informed mental health treatment (Behere et al., 2013). Earlier religious communities promoted superstitious, mystical and spiritual explanations around mental illness. In the middle-ages mental illness was largely viewed as insanity, this idea was rooted in demonology and the belief that a person's spirit can be exposed to unseen spirits that seek to cause harm (Behere et al., 2013; Eghighian, 2017).

In many religions mental illness has been seen as a result of sinful behaviour or moral failure. This particular belief that mental illness is due to moral failure has been found to have positive correlations with the presence of stigma (Wesselmann & Graziano, 2010). Anderson (1970) purports that witch trials were conducted on people living with mental illness (mostly women) as their behaviour was likened to witchcraft. The stigma that occurs from this belief

can support the religion-prejudice complex between mental health and religion (Wesselmann et al., 2010).

Religious explanations about mental illness can have an impact on the perspectives of treating mental illness (Leavy et al., 2017). During the 1970's an anti-psychiatry movement in Pentecostal circles was based on the belief that mental illness is a purely spiritual matter, thus treatment of mental illness should involve spiritual means such as prayer and pastoral counselling (McMinn et al., 2001). In the Bible, the healing of suspected mental health issues was accomplished through the expulsion of demons through miracles (Favazza, 1982). Wesselmann et al. (2010) found that Christians in their study who believe that mental illness is caused by sin or spiritual issues are more likely to offer spiritually orientated social support if care was needed for a mentally ill person. Leavy et al. (2017) argue that people of religious affiliation which adopt spiritual or moral failure as explanations of mental illness may delay in seeking medical attention for those with mental health difficulties. This approach to mental health can have adverse implications on vulnerable mental health patients in religious contexts.

However, religion has been seen to play a helpful role with recovery from mental illness. Koening et al., (2012) have seen that there exists a positive correlation between religion and mental health. For many, religion has been used as a source of comfort and coping, especially when under various types of distress (Koening, 2009). In their study about the impact of religious beliefs held by family members and health care workers on individuals living with schizophrenia, Smolak et al. (2013) found that religious beliefs had positive correlations with coping skills, response to treatment and treatment seeking. In general religion offers followers disciplines that promote healthy living that is beneficial for mental health and discourages poor coping skills such as alcohol and drug use (Brewer et al., 2014; Dein et al., 2012). Also, religion provides answers to existential issues and offers believers a sense of control over their

lives (Hayward & Krause, 2014). Therefore, we see that religion can assist members adopt positive coping skills and constructive cognitive processes.

2.6. Role of religious leaders in mental health

2.6.1. Global perspective

Health promotion in religious groups has historically been facilitated by religious leaders (Anshel & Smith, 2014). Stansbury et al. (2012) suggest that religious leaders across various countries offer counsel concerning health care issues and treatment options to congregational members. Religious leader's' position, skills and relationships with members provides them with an impactful platform to promote healthy living among affiliates (Anshel & Smith, 2014). Spiritual leaders provide not only spiritual teachings to congregants, but they often provide them with holistic approaches to health care and spirituality (Rivera-Hernandez, 2014). Also, Toh and Tan (1997) state that religious/spiritual leaders have significant impact on community members behaviour, emotional and thought process.

As stated earlier, religion assists congregants with adopting healthy coping skills and provides social support that assists with mental health (Behere et al., 2013). Religious leaders are seen to be significant sources of inspiring hope and assisting congregants and/or community members, particularly during distressful times (Hirono & Blake, 2017). A longitudinal study done by Krause and Hayward (2012) found that adults in the U.S will receive greater emotional support during or after encountering life distress, this would inspire more hope and resilience in these individuals. Religious leaders can help reinforce member's' faith and believing, which can have positive effects on positive coping skills and adaptive cognitive processes (Hayward & Krause, 2014). Youssef and Deane (2013) found that the beliefs held by Arabic-speaking religious leaders had an impact on how they engaged people with mental health issues and has a bearing on whether congregants are referred to mental health care services. Igbinomwanhia et al. (2013) found in their sample of Nigerian clergy that there exist pervasive negative

attitudes towards individuals with mental illness, this impacts the clergy's attitudes towards accessing mental health services to care for persons with mental illness. It is evident that religious leaders have a significant impact on the mental health of distressed congregants, this highlights the importance of their influence on mental health matters among their followers.

2.6.2. African Perspectives

Mental health in Africa is characterised by shortage of mental health services, adequate research and social stigma towards mental illness that stem from cultural and spiritual beliefs. In Ghana, there exists extensive stigma towards suicidal behaviour, particularly from religious communities (Osafa et al., 2011). Osafa (2013) states that in Ghana and most of Africa there exists a 'tradition of tension' between religion and scientific inquiry, this tension has its roots in the history of colonialism and has thwarted efforts to reconcile these camps. In their study of clergy as collaborators in mental health care in Nigeria, James et al. (2014) state that some clergy in their sample believe they can manage severe mental illness on their own. Also, James et al. (2014) asserts that clergy that believed in solely spiritual etiology of mental illness were not likely to seek help from mental health services.

However, there is evidence that suggests that some religious leaders hold modern psychiatric models of mental illness and use them to understand and treat mental illness. Ally and Laher (2008) found that Muslim faith healers in Johannesburg, South Africa were able to distinguish mental illness and 'spiritual illness', this allowed them to offer treatment advise as deemed fit. Kruger (2012), in their study on treatment of mental illness by Afrikaans speaking church leaders, saw that the sampled clergy mainly adopted a biopsychosocial-spiritual approach towards conceptualizing mental illness, however, the clergy in this study represented the Afrikaans middle-class. Many South Africans will access faith healers through churches for healing which highlights the reliance and belief in supernatural explanations for mental illness (Zabow, 2007).

However, Biopsychosocial Models of mental illness do not neatly overlap with cultural/spiritual beliefs about mental illness. Grobler (2011) conducted a case study of a complex psychosis in a ZCC church in Limpopo where a family presented with psychotic features of similar hallucinatory content, their presentation was best explained and treated according to the ZCC church beliefs and practices. The case study highlights the contested space that mental illness models share, particularly in spiritual communities. Approaches and explanations towards mental illness by religious leaders appear to vary, some adopt multi-dimensional approaches with others with a purely spiritual/religious approach, this has bearing on the treatment of vulnerable members and perceptions towards formal health care services.

2.7. Association between religion and health

2.7.1. Christianity

There are about 2.2- 2.3 billion people around the world who identify themselves as Christians, which consists of 31% of the world's population (Hackett & McClendon, 2017). Christianity is commonly thought to date back to the birth of Jesus Christ; however, its origins can be linked to early Judaism (Goodwin, 2012). Christian beliefs, doctrines and practices have been highly influential within language, education, politics, art, philosophy, law and moral thought (Woodberry, 2012). Also, Christian doctrines have saturated Western thought and have greatly influenced the global south (Manala, 2013).

Christianity is mainly based on the belief that Jesus Christ is the incarnate Son of God, who being deity, became a human and lived among people die for their sins and reconcile them to God (Hedrick, 2008). Christianity does share similar beliefs and historical depictions with Islam and Judaism (Votkovic, 2018). Christianity can be considered a worldview that provides an exhaustive explanation about life and existence. The Bible provides a worldview narrative that focuses on revealing the person of God and the role of man (humans) as His special creation (Theron & Lotter, 2009). Therefore, Christianity offers many of its subscribers a

worldview through which they understand and engage reality, this will be evident in understandings of its God, sin and health.

In history, the church has played an integral role in community welfare and development, it has also afforded those who identify with the Christian church a sense of meaning, support and belonging (Gallet, 2016; Magezi, 2017; Wesselmann et al., 2015). With Christianity's burgeoning influence since its formation, it has found itself in the frontlines of political, educational, and philosophical platforms (Pillay, 2017). Christian beliefs and churches also play a role in promoting social welfare and tackling social problems (Fagan, 1996). Ingrained in Christianity is the desire to impact family, community and societal living in accordance with Biblical teachings.

2.7.1.1. Christianity, evil and suffering

The Christian concept of sinfulness and the fall is a foundational belief that is used to understand suffering such as sickness and disease. The Bible stipulates that every human being is prone to sin and therefore carries the disposition towards immoral acts and imperfection (Willmington, 2018). The New International Version (2016, Romans 3:23) states that "or all have sinned and fall short of the glory of God" and (2016, Ecclesiastes 7:20) "Surely there is no righteous man on earth who does good and never sins". These texts highlight biblical emphasis on innate human evil (Willimington, 2018). These explanations about suffering and calamity parallel with beliefs about health and treatment in the Christian narrative.

2.7.1.2 Christianity and Health

Christianity conceptualises human beings as composed of multiple factors such biological, psychological, social, ecological and spiritual characteristics (Galvez, 2010). The human body, which is also understood as 'the flesh', is seen as corrupt and evil, and is impacted by environmental factors that further entrenche human suffering (Galvez, 2010). Hasel (1983)

states that the Bible understands a healthy individual as one who has wholistic harmony with themselves. A person's relationship with God and their obedience impact on their health outcomes, various biblical teachings suggests that illness can be influenced by a person's moral standing (Galvez, 2010).

The Bible suggests that the God's ultimate purpose is to 'restore people' and part of this restoration involves offering wholistic healing (Tyron, 2018; Hasel, 1983). Webb and Pennington (2019) put forward that when spiritual matters such as faith and morality are addressed, healing in a person's life is possible. Beck (2007) states that biblical teachings suggest that God can use health issues as means to highlight his power through miraculous healing. For an individual to enjoy health in the Christian perspective they are exhorted to have a harmonious relationship with God and people, while living a proactive lifestyle to care for themselves (Long, 2009).

The church can be seen as the focal point that can foster Christian based treatment that attend to a person's psychological, emotional, physical and social self (Long, 2009). Lategan (2017) analyses Apostle Paul's exhortation on the function of the church, he explains that in pursuit of its divine purposes the church is positioned to provide healthcare by tending to vulnerable community members, fostering restoration, encouraging positive relationships and using its message of righteousness to promote healthy living. Churches and clergy can function as community health care centres and CHW's and are often accessed first prior to formal medical services (Campbell et al., 2007). This highlights the importance of engaging the church community in providing health promotion, however this is facilitated by the beliefs held by Christians and their approach towards health (Chase-Ziolek, 2014).

2.7.1.3 Mental health and Christian beliefs

The relationship between Christianity and mental illness is historically laden with complexities, conflicts and progress. Many in the Christian sect uphold the belief that mental illness may be caused by that individuals' sins, a result of judgement, or even demonic possession (Stanford & McAlister, 2008). Porter (2002) cites the story of king Nebuchadnezzar where he was punished by God with 'madness' and overcome by mental illness. The Bible does appear to suggest that mental illness can be a direct punishment from God. Deuteronomy 28:28 states that "*The Lord will smite thee with madness, blindness and confusion of mind"* and Zechariah 12:4 says *"on that day I will strike every horse to panic and every rider to madness"* these beliefs may be informed by various interpretation of Christian understandings about mental illness symptoms, their origin and prognosis (Behere et al., 2013). Cook (2020) however suggests that the biblical narrative doesn't only view mental illness as a resultant from sin however prominent biblical figures struggled with mental illness without being in contradiction to their obligations to God. He also recognises that equating mental illness as being a resultant of sin does not account for the complex nature of mental illness because mental illness can impact spirituality and/or religiosity by impacting behaviour and moral obligations (Cook, 2020).

Wesselmann and Graziano (2010) suggest that the belief that mental illness is a result of sin/demonic possession can influence stigma amongst Christians towards those who are mentally ill. The conceptualisation of mental illness as sin or demonic possession has the propensity to attribute mental illness towards a person's moral depravity and lack of faithfulness, which can suggest that mental illness is the direct fault of that person (Mathison and Wade, 2009). These beliefs can be harmful when fundamentalist approaches are adopted to explain mental illness which can interpret Christian teachings in literal and stereotyped ways that are devoid of context and understanding (Peteet, 2019). Wesselmann and Graziano (2010)

suggest that stigmatising spiritual beliefs about mental illness are positively correlated with religious fundamentalism. The Christian community and their beliefs are therefore important factors in how mental illness is experienced.

The Christian community surrounding a person living with mental illness can be both helpful and potentially harmful to their wellness (Wesselmann & Graziano, 2010). There has been evidence that spirituality has positive correlations between adherence to and outcomes of treatment of depression, anxiety and substance use (Pillay, Ramlall, & Burns, 2016). Behere (2013) states that social support within Christian communities can assist people living with mental illness to adopt positive coping skills and reduced symptomatology. Studies have suggested that church attendance and religious affiliation can have positive correlations on lowered depressive mood (Ronnerberg et al., 2016; Sun et al., 2012).

Various studies have also noted that some people may deter from seeking pastoral services due to experiences of stigma, fear of shame, and the perceived lack of knowledge concerning mental health issues in clergy (Mathison & Wade, 2014; Quintana, 2013). In a study on social support from church and family members for depressive African Americans, it was found that social support from church members was significantly correlated with positive results in lowering depressive mood and negative social support has positive impact on increased depressive symptoms (Chatters et al., 2015). The beliefs, practices and approaches held by a church community can be impactful on the experiences of those living with mental illness, this can have either positive or negative connotations. A potential risk factor within religious communities is advocating mental health care that has the potential to adversely affect the sufferers (Wesselman & Graziano, 2015). It may then be important to investigate what informs Christian beliefs around mental illness and how this influence the church's approach to mental illness. The study offers the opportunity to understand how Christian explanatory

models of mental illness impact on attributions made about mentally ill church members, and this is implicated by the context in which the church members construct their beliefs.

2.8. Clergy involvement in mental illness

Several studies have found that individuals of Christian faith tend to consult churches and clergy for assistance regarding mental health issues (Agara et al., 2008; de la Porte, 2016; Heseltine-Carp & Hoskins, 2020). Churches become appealing for community members as they may offer affordable counselling services, religiously inspired intervention and culturally sensitive/inclusive services (VanderWaal et al., 2012). Clergy occupy positions of influence among church members, who look up to church leaders for assistance with emotional and mental health distress (Bledsoe et al., 2013). Also, with the limited range of psychological services available in South Africa, the engagement of religious leaders in mental health caring becomes an important resource of intervention (Kruger, 2012). As a result, church leaders find themselves, knowingly or unknowingly, as 'gatekeepers' of mental health (Stanford & Philpott, 2011; VanderWaal et al., 2012). Also, pastor's interpretation and approach towards mental illness are important as those views can influence their members belief about psychiatric care (Leavey et al., 2011). It becomes important to understand how clergy seek to approach mental illness among members counselling and treatment (Leavey et al., 2017).

The particular beliefs and knowledge that church leaders have about mental illness can have implications on their role in the type of intervention options they offer church members (Oppenheimer et al., 2004). Religious leader's' cultural background can impact their attitudes towards mental health and beliefs about its origin and nature, this has implications on the treatment of church members (Bledsoe et al., 2013). Church clergy's knowledge and culturally-based beliefs about mental illness are important factors to consider when considering their

assistance of people with mental illness, their knowledge and beliefs can also impact their perception of mental health services.

The cultural context in which churches and clergy exist in can play a role in how mental health is understood and addressed. In its essence, Christianity is seen as acultural yet it can be experienced and interpreted differently across cultures (Mwiti & Dueck 2006). Since mental illness is also understood as consisting of deviations from socio-cultural norms, it is important to consider the cultural context and the expected norms that are present, this also assists with understanding the presence of stigma in that context (Abdullah & Brown, 2011). Clergy's theological beliefs about mental illness can be based on their cultural context in which they exist, clergy may promote certain spiritual beliefs about mental health as they continue and fit their community's socio-cultural context (Leavey et al., 2011).

Westernised churches and clergy are more likely to avoid demonic explanations of mental illness due to their setting which promotes scientific, 'rational' approaches, whereas African traditional churches/Pentecostal churches will include demonic explanations as spiritual explanations from part of their cultural contexts (Leavey et al., 2011; Ensink & Robertson, 1999; Meyer, 2001). While reviewing pastoral counselling in differing cultural contexts Lartey (2002) pastors of varying ethnic communities will acknowledge and uphold differing beliefs about health and treatment. In their study, Payne (2009) found differences in beliefs about the etiology of depression between Caucasian and African American church leaders, Caucasian church leaders promoted a biological explanation of depression with African American church leaders believing that depression is due to difficulties in managing struggles in life and spiritual issues. Payne (2009) suggests that the cultural and ethnic background of a pastor has impact on their beliefs about mental illness and treatment. South Africa is a culturally rich country in which culture plays important roles in the lives of

individuals, following from Payne's (2009) expression, clergy's cultural background in South Africa may have implications on their approach towards mental illness.

2.9. Mental Health Treatment approaches- South African churches

South Africa is culturally complex country that is laden with multiple socio-historical factors that are evident in the present time. Pastoral and clergy's engagement with their communities and cultural context becomes important when they provide care services for their members (Klaasen, 2018). Pastoral care in South Africa had mainly followed Western modes of counselling however there has been a recent shift to acknowledge multicultural perspectives (Du Plessis, 2017). In the South African context, there have been limited studies that investigate how Christian beliefs and practices (in general) influence mental health perception, with existing studies identifying the link between spirituality and mental health (Pillay, Ramlall, & Burns, 2016; Janse van Rensburg, 2014).

Pastoral counselling is a form of treatment of psychological distress used by clergy for congregants, it has been found to be useful, especially in providing support to communities without access to mental health services (Neethling, 2003). Training for Pastoral counselling is available in various accredited educational sites such as UNISA, the University of Pretoria and various private organisations which offer the training. However, Pastoral counselling qualification are not regulated by the HPCSA according to the terms it stipulates (Neethling, 2003). Stanford and Philpott (2011) state that clergy have admitted that pastoral training does not equip them well enough in mental health issues. When members of clergy do not have sufficient knowledge in medical procedures and conditions of confidentiality this can hamper their ability to assist with mental health related issues (Bledsoe et al., 2013).

Kruger (2012) explored Afrikaans speaking pastor's approach to mental health treatment in Limpopo, South Africa and found that many of these pastors adopted a

biopsychosocial and spiritual approach towards conceptualising mental illness. The participants mainly stated that their role in severe mental illness treatment is restricted and may refer to psychiatrists and psychologists, however they are involved in assisting with other mental illness through counselling and visits, yet if they perceive that the mental illness is from a spiritual issue, they would engage in prayer (Kruger, 2012). The current study could not identify further studies in South Africa which investigate clergy's representation of mental illness and their referral pathways, highlighting the paucity of studies in this topic. This may highlight a lack of interest in this topic, however, as mentioned above, engaging clergy in mental healthcare can an important aspect of providing mental health care in communities, particularly those who exist in communities with low access to formal mental health care, such as South Africa.

2.10. Summary

This chapter reviewed aspects of various mental health models that are generally used to explain and understand mental illness. Explanatory models of mental illness provide frameworks that form a basis on beliefs about mental health etiology and treatment. Literature highlights the important role religious leaders have in health promotions among their congregants and can have influence on their help-seeking behaviour. In the African continent, religious leader's' may hold more active roles in mental healthcare due to the mental health treatment gap in the continent, however spiritual explanations and treatment do not always coincide with modern psychiatric approaches. Literature sheds light on the role of Christian beliefs in conceptualising mental illness and treatment, these beliefs offer the study a guide on Christian clergy's approaches towards mental healthcare and treatment. However, there is a lack of studies in South Africa that aim to investigate clergy's representation and treatment of mental illness, studies investigating this topic are needed to better engage mental health treatment in churches and communities at a broader level.

2.10.1. Problem statement

As observed above, Christianity plays integral roles in the lives of various communities and cultures, and holds considerable influence on their worldviews, particularly mental illness. Church leaders and clergy are seen as gatekeepers of mental health among their congregational community, and their beliefs, perceptions and doctrines around mental illness are important topics to be investigated. As discussed above, Christian beliefs and mental illness share a complicated dynamic that is influenced by conceptualisations and treatment which have lend themselves towards stigmatising behaviours and beliefs about mental illness. This dynamic introduces important issues around clergy's mental health identification, their roles and referral behaviour. This guides the study to consider the scope of evidence that exists which contains information concerning church leader's' perception of mental illness, its identification and subsequent remediation strategies that clergy use. The study aims to map the evidence in an attempt to ascertain the narrative that the research provides about the clergy mental health beliefs and perceptions, identification and remediation.

2.10.2. Study Rationale

Task-shifting has increasingly become an integral part of mental health service delivery, as it emphasises the roles of CHW's within communities to provide mental healthcare as primary health care services become constrained by the great need for these services (Spedding et al., 2014; Eaton et al., 2011). Church leaders and church counselors can prove to be useful alternatives of mental healthcare as they hold influential roles among their congregation and communities and provide space for compassionate care of vulnerable church members (Iheanacho et al., 2015). The study attempts to highlight the current trends of clergy's perceptions of mental illness and how it informs identification and remediation pathways. The study aspires to provide insight on these current trends and provide a landscape of evidence

which can inform future studies and provide information that fosters insight which can assist to better collaborations between formal health services and church clergy.

Chapter 3: Methodology section

3.1. Research Methodology

This describes the methodological approach that informed the following: study design, criteria used to elicit the final data sample, the research procedure, and the data analysis process that informed by the study design. The scoping review protocol was used to synthesise and map the range of evidence from literature about the research topic. The protocol was guided by a scientific process aimed specifically at illustrating studies that have met stringent inclusion and exclusion criteria to determine their suitability (i.e., must demonstrate adequate levels of validity in relation to the area under study – see section 3.2.1.2.2 for details) to be eligible for the final data set.

3.1.1. The research questions that the study answers:

- What evidence exists regarding how Christian beliefs of church leader influence their perception of mental illness?
- What evidence exists regarding how church leaders/representative's beliefs inform their identification of mental illness?
- What evidence exists regarding how these beliefs inform the mental health interventions?
- What evidence is there regarding the preferred referral pathways subscribed by church leaders for mentally ill congregates?

3.2. Research Design

The study design took the form of a scoping review. Scoping reviews are studies that aim to map the evidence and themes that underlie a research topic by synthesising data through a systematic process of collating exploratory data in for the purpose of consolidation our understanding of existing knowledge in the area of study (Mays, Roberts, & Popays, 2001). Scoping reviews are a recent research method for data synthesis and has many variations to systematic reviews (Sucharew & Macaluso, 2019). Scoping reviews aim to provide a broad 'scope' of evidence and can give an account of the volume of literature available on a certain topic (Munn et al., 2018). Whereas systematic reviews are aimed at answering a specific question about literature and is helpful in reviewing the quality of evidence available (Munn et al., 2018). Scoping reviews can often precede Systematic Reviews as they can offer an overview of the body of evidence before specific questions about a topic can be posed (Munn et al., 2018). Scoping reviews and systematic reviews are similar research methods that make use of comprehensive and structured literature sourcing and map available literature (Sucharew & Macaluso, 2019). The difference between these two approaches lie in their purposes, criteria for sourcing literature and their use of evidence (Munn et al., 2018). Munn et al. (2018) suggest that the intended use of the results is the main difference between the research methods, systematic reviews are concerned with research protocol and their impact on issues around intervention effectiveness, however scoping reviews intend to cover themes and provide a narrative for the data. Also, systematic reviews deal with specific research questions while scoping reviews allow for different types of research studies to be researched (Dijkers, 2015).

Scoping reviews are useful tools in helping garner information on emerging topics and data and help garner a narrative on the broad evidence pertaining a research question (Munn et al., 2018). Arskey and O'Malley provided a blueprint on how to conduct scoping reviews which have been seen as the guiding framework for researchers embarking on this methodology

(Munn et al., 2018). The use of scoping reviews is specific and is mainly guided by the following objective according to Munn et al. (2018):

- To identify the types of available evidence in a given field
- To clarify key concepts/ definitions in the literature
- To examine how research is conducted on a certain topic or field
- To identify key characteristics or factors related to a concept as a precursor to a systematic review
- To identify and analyse knowledge gaps

To conduct a successful scoping review, it is important that the research aims and purposes are in tandem with the overall purposes of a scoping described above (Sucharew & Macaluso, 2019).

Arksey and O'Malley (2005) have been touted to have structured the methodological framework for scoping review. Arksey and O'Malley (2005) provided 6 steps (however the last stage is optional) in conducting scoping reviews, these steps are:

1. Identify the research questions: what domain needs to be explored?

2. Find the relevant studies

3. Select the studies that are relevant to the question(s)

4. Chart the data, i.e., the information on and from the relevant studies

5. Collate, summarize and report the results

6. (Optional) consult stakeholders (clinicians, patients and families, policy makers, or whatever is the appropriate group) to get more references, provide insights on what the literature fails to highlight, etc.

3.2.1. Scoping review research steps:

3.2.1.1. Identifying the research question

When conducting scoping reviews, the research questions are kept broad in order to allow a wide range of literature to be synthesized (Levac et al., 2010). Levac et al. (2010) suggest that for an efficient analysis of literature scoping research should have a broad research question with a specific inquiry scope, this would involve defining concepts, population and any other parameters necessary for the research. In order for this to occur, the research needs to clarify the purpose/objective of the scoping review, this will allow for systematic inquiry in latter stages (Levac et al., 2010; Khalil et al., 2016). Also, the scoping review should take consideration of the context of the study to better define the research question (Khalil et al., 2016).

This study's broad research questions are (1) What evidence exists regarding how Christian beliefs of church leader influence their perception of mental illness? (2) What evidence exists regarding how church leaders/representative's beliefs inform their identification of mental illness? (3) What evidence exists regarding how these beliefs inform the mental health interventions? (4) What evidence is there regarding the preferred referral pathways subscribed by church leaders for mentally ill congregates? The aim of this study was to map and synthesize literature that have investigated how church leaders' Christian beliefs influence their perception, identification and intervention of mental health problems in congregants.

3.2.1.2. Find the relevant studies

In order to achieve adequate reliability and validity, specific inclusion and exclusion criterion were developed with the use of primary and secondary search terms that assisted in refining the search for relevant literature. The researcher subscribed to available academic

research databases (see section 3.2.1.2.1) in order to elicit the desired outcome (i.e., studies that met the prescribed criteria in order to achieve the specific aim and objectives. Further to this, the researcher identified cited authors and searched primary studies illustrated in the reference sections of certain articles that were aligned to the topic under study. The PCC (Population, Concept, Context) framework was used to order search terms during the process of identification and inclusion.

3.2.1.2.1. Information Sources

The researcher made use of multiple databases and information sources to identify the relevant studies such as peer reviewed journal articles, grey literature, quantitative, qualitative and mixed methods studies. The initial search process was based on the use of primary search terms guide the initial search for data sources. Primary search-term strings were constructed and reconstructed to allow for diverse hits on the various database. Database used: Google scholar search, UKZN icatalogue, Ebscohost, Pubmed, Springer Link and Reference lists of identified studies. The search terms will also be used to access hard to reach Gray literature. Varying search strings were made for different database to attempt limiting replications and sourcing varying data.

3.2.1.2.2. Eligibility criteria

For literature to be considered part of this research they had to fulfil the following criteria:

Table 1.

INCLUSION	**EXCLUSION**
Quantitative, qualitative and mixed methods study designs, grey literature, peer reviewed articles, scoping reviews and systematic reviews	-

Christian leaders, church counsellors, clergy	Health-care professionals, non-Christian spiritual leaders, church members/congregants
Christian beliefs of Judeo-Christian background	Non-Christian religions
Literature published from the year 2010 to 2020	Literature published before 2010
English articles	Articles not translated into English
Mental health	Physical health
Global literature	
Pastoral counselling/church interventions attending mental illness related issues	Pastoral counselling and non-mental health related issues, church health interventions
Studies focused on Christian perceptions of mental illness	Cultural conceptualisations of mental illness
Studies focused on Depression, Anxiety, mental distress and Psychosis.	Other mental health related issues (e.g. PTSD, personality disorders, Bipolar disorder, etc)

Table 2.

Primary search terms

Population	Concept	Concept
Church leaders	Perceptions of mental illness	Treatment of mental illness
Church representatives	Attitudes about mental illness	Referral pathways
Clergy	Beliefs about mental illness	

Table 3.

Secondary search terms

Population	Concept	Concept

Pastors	Beliefs about mental illness	Counselling
Church counsellors	Perceptions about mental health	Formal health care services
clergy	Knowledge and attitudes about depression	Psychotherapy
		Spiritual interventions

The study focussed on depression, anxiety, psychosis and mental distress as the focal mental health issues. Within Christianity, psychotic disorders have historically been conflated with demonic influence, witchcraft and sinfulness, therefore including psychosis as a predominant mental health outcome, directed the search for evidence around this dynamic and sought to understand clergy's perception of this mental health condition (Grover, Davuluri, & Chakrabarti, 2014).

As part of the search strategy the researcher conducted a preliminary search on Pubmed for relevant articles or journals which fit the criteria that has been prescribed according to the needs of the research. Using Pubmed, the MeSH database was used to identify terms the most relevant sub-terms which then were to be included in the search string. The initial search involved using terms and subjects that emanate from concepts contained in the research question and objectives. The initial concepts identified were Clergy, beliefs/attitudes, Mental illness, mental illness Identification, and, mental illness Remediation. Each concept was searched through the Pubmed MeSH database and yielded various terms which matched the concepts as necessary for the study. These terms were then grouped together and arranged accordingly with the appropriate Boolean phrases to construct a search strategy to be used across databases. Various terms were truncated (marked by the '*' symbol) to enable databases to identify varying forms of a term, this allows the search to identify relevant literature which

may contain terms and subjects that reflect the needs of the study. The following search string was used to identify the appropriate literature for the study:

> *(Clergy* OR Pastor* OR minister* OR priest* OR cleric* OR chaplain*)* AND *(Health knowledge OR Attitude* OR perception* OR belief*)* AND *(Mental disorder* OR Mental distress OR Depression OR Anxiety OR severe mental disorder* OR Mental health OR diagnosis)* AND *(Psychiatric rehabilitation OR Treatment* OR referral pathway* OR counselling OR psychotherapy OR spiritual intervention*)*

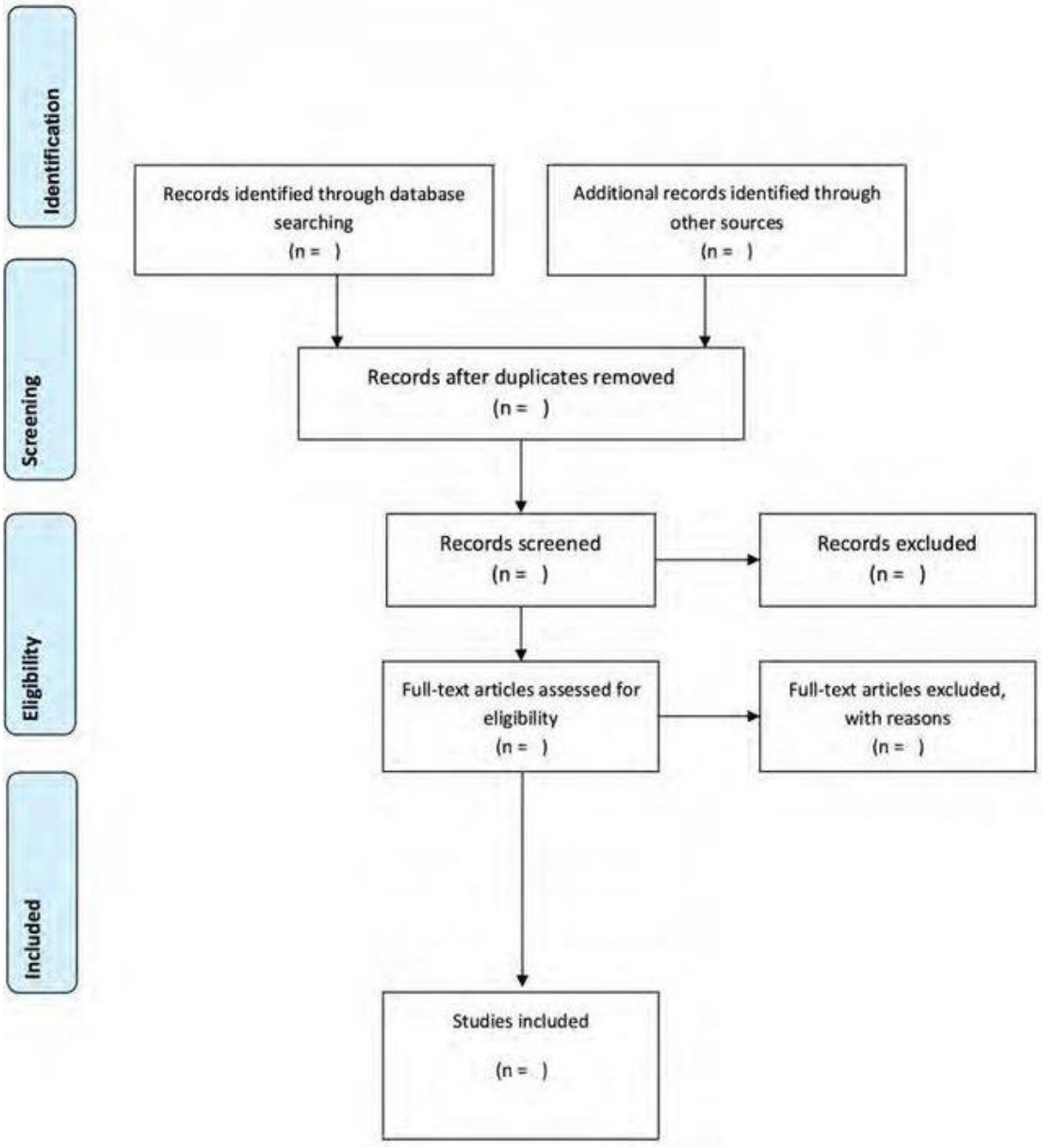
3.2.1.3. Select the studies that are relevant to the question(s)

The study selection stage required at least two reviewers to be involved in the study review process. This stage involved screening and retrieval of research abstracts and full text articles. Article abstracts were evaluated in accordance with specific criteria (i.e., inclusion & exclusion criteria). Research databases were selected, with search terms screening for applicability in relation to the following: title selection, abstract selection and text selection (using indicated Boolean terms). Duplicate studies were removed from the final list of included articles.

During the title selection search all the titles searched were downloaded and added on a search database on Endnote as a means to keep a systematic account of the search process. The abstract selection stage involved a comprehensive assessment of the literature abstracts according to the predetermined inclusion and exclusion criteria. A separate set of folders were created for articles that were included, rejected or yet undecided.

The outcomes of the screening were reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses ScR (PRISMA-ScR) flow diagram, as shown below in figure 1.

Figure 1. Example of Preferred Reporting Items for Systematic Reviews Meta-Analyses-ScR (PRISMA-ScR extension for Scoping Reviews) flow diagram for the scoping review process (Tricco et al., 2018).



3.2.1.4. Chart the data, i.e., the information on and from the relevant studies

Data charting will involve a descriptive process in which the findings of the study will be summarised (Khalil et al., 2016). This process will involve outlining the literatures chosen according to various descriptive markers such as the author(s), date of publication, origin of source, location of study, research aim and purpose, study population and sample size, methodology, intervention type, duration of intervention, review of outcomes and key findings (Khalil et al., 2016).

Table 4

Charting the data
Author(s):
Date of publication:
Origin of source:
Location of study:
Research aim and purpose:
Study population and sample size:
Methodology:
Intervention type:
Duration of intervention:
Review of outcomes:
Key findings:

3.2.1.5. Collate, summarize and report the results

The results section of this dissertation incorporates descriptive analyses of articles included in the final data set. Descriptive statistics were used to illustrate variables such as the year, location, themes, types of interventions etc. Thereafter, thematic analysis was used (see section 3.6 below) for analysing and synthesising information according to prominent themes

that emerged from the data (Braun & Clarke, 2006). As a scientific procedure, thematic analysis incorporates interpretation and understanding data according to a set of meanings held by the person/s in question. These meanings assist researchers in ascertaining processes that foster beliefs and behaviour (Braun & Clarke, 2012). Thematic analysis affords the researchers the ability to compare data with themes and concepts, and relate them with the research question (Alhojailan, 2012). Thematic analysis will allow the study to form analysis about how Christian church leaders understand mental illness according to their Christian beliefs, and through a scoping review data from literature will be synthesised to assess for common themes and understandings.

3.3. Search strategy

Accessing studies investigating church leader's representation of how Christian beliefs inform mental illness identification and remediation (referral pathways) in vulnerable church members was accomplished by searching journals in the following disciplines: psychology, psychiatry, and theology. In this instance, various online databases were accesed (e.g. Google Scholar, Ebscohost UKZN - Medline and Academic Search Complete, Pubmed, and Springer). The search criteria were restricted to English or English translated studies. The search outcomes yielded studies and articles that were further filtered according to the inclusion and exclusion criteria. This is illustrated in Table 5 below.

Table 5

Search strategies and yields for electronic databases (Dates accessed: 17 – 23 Aug 2021)

Database	Search Strategy	Yield	Total Relevant Study
Pubmed	(Clergy* OR Pastor* OR minister* OR priest* OR cleric* OR chaplain*) AND	365	37

	(Health knowledge OR Attitude* OR perception* OR belief*) AND (Mental disorder* OR Mental distress OR Depression OR Anxiety OR severe mental disorder* OR Mental health OR diagnosis) AND (Psychiatric rehabilitation OR Treatment* OR referral pathway* OR counselling OR psychotherapy OR spiritual intervention*)		
Academic Search Complete (Ebscohost)	(Clergy* OR Pastor* OR minister* OR priest* OR cleric* OR chaplain*) AND (Health knowledge OR Attitude* OR perception* OR belief*) AND (Mental disorder* OR Mental distress OR Depression OR Anxiety OR severe mental disorder* OR Mental health OR	278	39

	diagnosis) AND (Psychiatric rehabilitation OR Treatment* OR referral pathway* OR counselling OR psychotherapy OR spiritual intervention*)		
Springer Link	(Clergy* OR Pastor* OR minister* OR priest* OR cleric* OR chaplain*) AND (Health knowledge OR Attitude* OR perception* OR belief*) AND (Mental disorder* OR Mental distress OR Depression OR Anxiety OR severe mental disorder* OR Mental health OR diagnosis) AND (Psychiatric rehabilitation OR Treatment* OR referral pathway* OR counselling OR psychotherapy OR spiritual intervention*)	2191	17

Medline (Ebscohost)	(Clergy* OR Pastor* OR minister* OR priest* OR cleric* OR chaplain*) AND (Health knowledge OR Attitude* OR perception* OR belief*) AND (Mental disorder* OR Mental distress OR Depression OR Anxiety OR severe mental disorder* OR Mental health OR diagnosis) AND (Psychiatric rehabilitation OR Treatment* OR referral pathway* OR counselling OR psychotherapy OR spiritual intervention*)	278	18
TOTAL YIELD		3 112	131

3.4. Criteria for Inclusion

Table 6 below demonstrates the inclusion and exclusion criteria that the study used, the criteria was organised according to study design, population specifications, concept, context, and language.

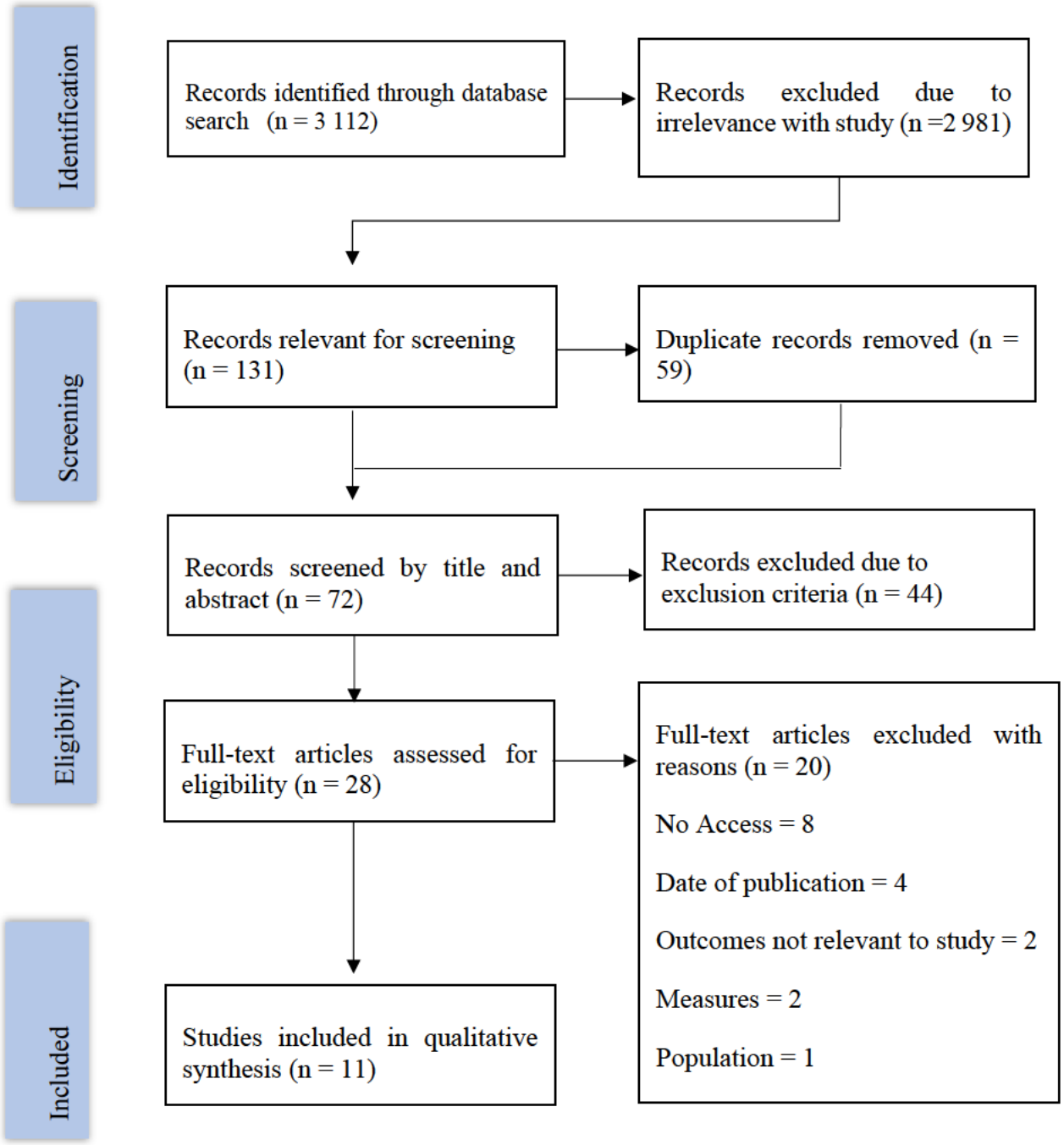
Table 6.

Criteria	Inclusion Criteria	Exclusion Criteria
Study Design	Quantitative, qualitative and mixed methods study designs, scoping reviews and systematic reviews	-
Population	Christian church leaders, clergy, Pastors, Ministers, Chaplains	Health-care professionals, non-Christian spiritual leaders, church members/congregants
Time	Literature between 2010-2020	Literature from before 2010
Concept	Studies focused on Depression, Anxiety, mental distress and Psychosis.	Other mental health related issues (e.g. PTSD, personality disorders, Bipolar disorder, etc)
Context	Christian beliefs of Judeo-Christian background	Non-Christian religions
	Studies investigating clergy perceptions and beliefs about mental illness/Psychological well-being and subsequent treatment/referral pathways	Studies investigating clergy perceptions and beliefs about physical health
Language	English articles and articles which have been translated into English Articles	Non-English articles

3.5. Study Selection

The search strategy yielded study title and abstracts which were compared with the requirements of the inclusion and exclusion criteria to assess for adequate studies. Duplicate articles across databases were removed. Articles that met the criteria during the title and abstract stage selection were then reviewed by full text and were then assessed according to the inclusion and exclusion criteria as already mentioned in table 6. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses-ScR (PRISMA-ScR) flow diagram demonstrated in figure 2 below:

Figure 2. PRISMA-ScR flow diagram of the selection process



As illustrated in figure 2 above, the PRISMA-ScR flow diagram shows that the total tally of identified titles was 131. A total 2 981 studies that did not meet the criteria were excluded from the search. There were 59 duplicate articles that were identified and excluded from the search. 72 studies were identified to be screened further. 44 studies were excluded during the title and abstract screening after not meeting the criteria, 28 studies remained for full-text screening. 8 full-text articles could not be accessed.

3.6. Data Analysis

The researcher made use of thematic analysis to understand the culturally contextualised themes that may be elicited from the data. Thematic analysis is the procedure of picking out patterns and themes that are to be analysed according to the needs of the research (Maguire & Delahunt, 2017). Thematic analysis is a useful research tool that can lend itself to answering a variety of research questions and attending to various research frameworks (Kiger & Varpio, 2020). Qualitative studies often benefit from thematic analysis as it allows for layered, contextual understandings of data and can assist link that data to broader socio-cultural discourse that can contextualise findings (Kiger & Varpio, 2020). The current study was interested in charting and reviewing data from literature that sought to gain understandings around clergy's perception of mental illness and their remediation methods, using thematic analysis allowed the study to further make sense of the evidence that emerged from literature.

Braun and Clarke (2013) have constructed a six-step model which the study will use to analyse the data. Step 1 is becoming familiar with the data, this involves the researcher immersing themselves in the data they have received by reading and re-reading the transcripts; step 2 would be to generate initial codes where the researcher would specify codes for the patterns that are surfacing from the data; step 3 would be to search for themes according to the

coded information, the researcher would generalise themes that have surfaced from the various data sources; step 4 involves assessing the themes to check whether they fit and are relevant to what the data is saying, it would then be important to check if the themes make sense according to the data; step 5 is defining the themes in which the identified preliminary themes are seen to capture the essence of what the data describes; step 6 involves writing up the themes and presenting them in a succinct manner which fits with the entire profile of the study (Braun & Clarke, 2013). The current study identified themes that were relevant to the research objectives and themes that were prominent across the data and useful in answering the questions raised by the study. The study made use of a deductive approach of thematic analysis, allowing the data to emerge with the themes necessary to understand the research topic. The discussion section in chapter 4 will epitomise this process and make sense of the themes that were identified.

3.7. Ethical considerations

Scoping reviews are also known as ‘desktop research’ and rely on secondary data from various studies. The study did not access confidential or private information. Articles were accessed using academic search engines and databases subscribed to by the University of KwaZulu-Natal. The review focussed on existing research that sampled church leader’s representation of how Christian beliefs inform mental illness identification and remediation (referral pathways) in vulnerable church members.

3.8. Limitations of Methodology

Scoping reviews are not without limitations. Scoping reviews are not concerned with reviewing the quality of the study and research study designs, this may raise concerns of reliability about the information presented (Sucharew & Macaluso, 2019). Scoping reviews require an extensive search process and can therefore become time consuming (Sucharew & Macaluso, 2019). In their nature, scoping reviews do not offer a final answer to a specific

research question, the researchers must rely on their analysis to formulate a specific answer (Sucharew & Macaluso, 2019). Also, scoping reviews can potentially be biased if the search process is not extensive and inclusive of available data, this can impact the validity of the results (Sucharew & Macaluso, 2019).

Chapter 4: Results and Discussion

4.1. Introduction

The chapter comprised of two sections, the first being the Results (section 4.2), and the second being the Discussion (Section 4.3) in the chapter. The results section in the chapter illustrates descriptive and narrative statistics extracted from the selected studies which offered a background to the discussion section. The discussion section of the chapter focused on discussing the emerging themes and narratives that the data provides, and critically analyse the influence of contextual factors. Analysis of the data was conducted using thematic analysis which allowed for a systematic process of drawing rich and contextual narratives that resonate with the research question and study objectives.

4.2. Results

4.2.1. Summary of Literature

Christianity is the world's leading religion with 2.38 billion followers across the world (Hacket & McCledon, 2015). Based on these figures, it appears that the beliefs and values associated with Christianity influence many societies across the globe (Pillay, 2017). Approximately 792 million people worldwide live with some form of mental illness, this translates to a little over 10% of the world's population, however a majority of this population,

most of which live in developing and underdeveloped countries, don't have access to appropriate mental health services (Charlson et al., 2019; Saraceno & Saxena, 2002). Mental healthcare services differ in accessibility and quality between high- income and low- income countries. In high income countries there are approximately 11.9 mental health workers for 100 000 people, however in low- income countries there are 0.1 mental health workers per 100 000 people (WHO, 2017). The African continent has a shortage of mental health workers with 1.4 mental health workers for 100 000 people, this is below the global average of 9.0 mental health workers per 100 000 people (WHO, 2014). Sierra Leone exemplifies the service delivery gap within low- income countries as an estimated 98.8% of people in need of mental health services do not access services (Yoder et al., 2016). Green and Colucci (2020) state that most low- to middle income countries will rely on traditional or religious leaders for mental health treatment due to the poor access to formal mental health services. Given the above statistics, it appears that people living in under-resourced areas have subscribed to traditional and spiritual healers as a primary source of assessment and intervention in relation to mental illness (Sorsdahl et al., 2009).

Given the above statistics, it appears that people living in under-resourced areas have subscribed to culturally based community health care as a primary source of assessment and intervention in relation to mental illness (Sorsdahl et al., 2009). The Christian church has been able to provide psychosocial care services towards congregants and assist vulnerable members who may be experiencing various forms of psychological distress (Heseltine-Carp & Hoskins, 2020). However, the types of care and interventions clergy and pastoral counsellors engage can vary according to their educational background, denomination and access to health services. Traditionally, clergy have provided spiritual and emotional care for congregants through their various structures and interventions. Vulnerable members may prefer accessing clergy for mental healthcare as they can offer more affordable and accessible treatment which appeals to

their cultural and religious beliefs (VanderWaal et al., 2012). Pastoral counselling is a common treatment intervention that clergy use, this may be due to encountering church members with psychosocial issues impacting their mental health (Mollica et al., 1986). Pastoral counselling has been seen to also involve spiritual elements such as prayer, scripture reading and faith healing, this is especially true when the issue is deemed a spiritual problem (Young et al., 2003). Church leaders are also well positioned to offer referral networks for vulnerable members in need of mental health services. In a study by Hernandez (2012) clergy that have some form of training or understanding of mental illness were seen to refer cases of serious mental illness that may be beyond their ability to treat (Hernandez, & Sandman, 2012). Young, Griffith and Williams (2014) saw that African American clergy in their study regularly use pastoral counselling and encounter serious mental health issues of which they regularly refer to mental health practitioners. Findings from Mason et al. (2021) suggest that clergy can also act as suicide prevention gatekeepers through identifying at risk persons and referring to the adequate treatment option. This highlights the important role clergy play in the delivery of mental healthcare in their church communities, further exploration of this can shed light into the dynamics that exist between clergy and mental health services.

Christianity and mental illness have a contrasting and complex relationship, with a history marked with various positive and negative interactions/outcomes. The church has historically been viewed as an access point for communities to gain various forms of social support and assistance with managing distress (Behere, 2013). However, Christianity has also been historically linked with stigmatising beliefs about mental illness that can stem from doctrinal beliefs, these beliefs can be in conflict with evidence-based scientific understandings of cause-effect pathways in mental illness (Wesselmann and Graziano, 2010). Regardless of the nature in the interaction between Christianity and mental illness, religious beliefs, both

historical and current, play an impactful role in how mental illness is conceptualised and treated within the church community.

Church clergy can be viewed as mental health gatekeepers in the Christian community who are able to offer spiritually based health care that vulnerable church members can relate with (Behere, 2013). However, contrary evidence (Sternthal et al., 2010) suggests that vulnerable church members in need of mental health services may avoid consulting clergy as they may contribute towards perpetuating the social stigma associated with mental illness and engage in potentially harmful treatment. The above points place emphasis on the importance of church clergy's beliefs about mental illness as they may offer insight into their treatment and referral practices for vulnerable church members. They also provide a reasonable basis towards mapping and synthesising information regarding clergy's beliefs regarding mental illness and offers insight into how such beliefs may influence treatment and referral pathways for vulnerable church members. The current study mapped and synthesised literature to garner the current narrative on church leader's perceptions of mental health and their subsequent treatment/referral pathways. The studies objectives were: To explore existing evidence of church leaders' perceptions of mental illness and their role in remediation and treatment; to explore and understand how Christian beliefs inform perceptions of mental illness; to identify preferred intervention/referral pathways (i.e., religious and/or mental health professionals). A scoping review was conducted in attempts to understand the scope and narrative of the research topic.

4.2.2. Data Charting table

Table 7.

Author(s); Year	Study Title	Aims and Objectives	Operational Definition of Christian beliefs/Mental illness	Methodology	Results
1. Aramouny, C., Kerbage1, H., Richa, N., Rouhana, P., Richa1, S. (2019)	Knowledge, Attitudes, and Beliefs of Catholic Clerics' Regarding Mental Health in Lebanon	The study aims to evaluate the knowledge, attitude, and beliefs of Christian religious men on mental health and illness and tried to correlate them to the participants' sociodemographic characteristics. .	Clergy in this study are from the Catholic and Maronite tradition. Focused on mental illness in general	Using a cross-sectional study design, a standardized questionnaire was administered during a 30-min interview with Lebanese religious men of different denominations (Catholic Christian, Maronite Christian), in various regions of Lebanon, concerning their attitudes, perceptions, and knowledge about	Our results indicate that religious leaders believed that psychosocial factors and drug and alcohol addiction were the most important causes of mental illness. There was a great deal of uncertainty about whether hereditary factors were a cause of mental illness, although

				mental health. Questionnaires were available in French and Arabic versions. They were translated into Arabic and French by two different certified translators. All questionnaires were administered in a meeting with the participants	around three quarters of participants believed chemical imbalance in the brain was an important cause. The interesting finding in our study was that few clerics named religious causes. In our study, 84.9% thought they could recognize a patient with mental illness, 66.7% had provided help to a patient with mental illness, and 63.2% had referred a patient with mental illness to a mental health professional.
2. Asamoah, M. K. Osafo, J and Agyapong, I. (2014)	The role of Pentecostal clergy in mental health-care delivery in Ghana	the purpose of this study is to examine the role Pentecostal clergy play in	Christian beliefs are viewed in the lens of Pentecostalism.	The sample comprised twenty 20 clergy. These pastors were purposively sampled.	the participants hold unto a supernatural paradigm of the aetiology of mental illness. The

		mental health-care delivery in Ghana and the potential difficulties they face	Focused on mental illness in general	The interviews were carried out face-to-face at School of Theology and Missions of the Central University College.	perceived roles of Pentecostal pastors in mental health-care delivery as indicated in this study is to a large extent a consequence of how they conceive mental illness. The two major roles of spiritual diagnosis of the problem and engaging in deliverance and healing derive from the diabolical conceptualisation of mental illness
3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014)	Ministers Perceptions of Church-Based Programs to Provide Depression Care for African Americans	The purpose of this study was to conduct focus groups with ministers from one of the largest black churches in the US to learn their views on depression and the feasibility of implementing	The study focused on clergy from the Methodist tradition. The study focused on depression as understood in the DSM-IV.	21 ministers were recruited to conduct focus groups using an open-ended, semi-structured interview schedule. Each focus group lasted 90 min. Each minister received a $30 fee	Ministers described depression within a context of vast suffering in the African American community. The ministers viewed the screening assessment as a way to educate

		church-based programs for MDD		upon completing the study	parishioners about the symptoms of depression
4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017).	Mental health literacy in religious leaders: a qualitative study of Korean American Clergy	The aim of the current study was to explore the knowledge and beliefs about depression held by Korean American clergy, using a qualitative approach.	Denomination unspecified Focused on mental illness in general	Seventeen clergy members serving in Korean communities in two U.S. metropolitan cities participated in an individual in-depth interview.	The overall findings suggest that there were some variations in beliefs and knowledge about causes, risk factors and treatment for depression among the Korean American clergy interviewed. It was notable that some comments from participants reflect lack of knowledge of depression and stigma.
5. Karadzhova, D., & White, R. (2016).	Between the 'Whispers' of 'the Devil' and 'the Revelation of the Word': Christian Clergy's Mental	The specific aims of the current exploratory, qualitative descriptive study are to explore the various	The denominational traditions that were represented were Pentecostal, Independent, Catholic, Seventh-Day Adventist.	This qualitative study (N = 10) used interviews to investigated the pastoral practices, mental health literacy	The majority of the respondents expressed symbiotic beliefs about the significance of

	Health Literacy and Pastoral Support for BME Congregants	aspects of the mental health literacy (Jorm et al., 1997) of Glasgow-based Christian clergy leading predominantly BME congregations	The study investigated Mental Health literacy around Depression, Anxiety and Schizophrenia/Psychosis.	and referral tendencies of Christian clergy serving BME congregants in Glasgow, Scotland.	socio-economic, environmental, spiritual, biological, cognitive and psychological factors for one's (mental) wellbeing. Respondents promote referral to mental health professionals and have developed skills in detecting MI. In the current sample, spirituality and faith were viewed as vital components of one's well-being, however, those beliefs did not seem to interfere with the other causal beliefs that the clergy held or with their stated intentions to make a referral
6. Kpobi, L. N. A., & Swartz., L.	'The threads in his mind have torn': conceptualization	The aim of this paper is to examine the beliefs of charismatic	Christian beliefs were operationalised as neo-Pentecostal/charismatic	We interviewed neo-prophetic pastors who undertook faith	The data suggest that the pastors' conceptualization

	and treatment of mental disorders by neo-prophetic Christian healers in Accra, Ghana	Christian faith healers about mental disorders and their perceived effects, as well as to describe their treatment methods, as a contribution to the discourse on finding holistic collaborative care for mental disorders in Ghana	Christian theology is built on the experience of the Holy Spirit and its gifts such as prophecy, miracles and speaking in tongues. Focused on mental illness in general	healing, and examined their work relating to mental disorders. Ten pastors from eight churches in the Greater Accra Region of Ghana were interviewed using semi-structured interviews.	of mental illness was generally limited to psychotic disorders. Their beliefs about causation were predominantly supernatural in nature although they acknowledged that drug misuse and road traffic accidents were also potential causes. Their diagnostic and treatment methods revolved around using prayer, prayer aids such as oils and holy water, as well as spiritual counselling for patients and their caregivers. However, they were not opposed to referring patients to hospitals when deemed necessary

7. Leavey, G. (2010)	The Appreciation of the Spiritual in Mental Illness: A Qualitative Study of Beliefs Among Clergy in the UK	This study was undertaken in an attempt to understand how and why clergy respond when contacted by people who are experiencing symptoms of mental distress.	Denominational representation included Pentecostalism, Catholicism and The Church of England (Anglican). Focused on mental illness in general	A qualitative design using a semi-structured interview was used because it was the most appropriate approach for developing a rich understanding of how clergy perceive, interpret and respond to the sort of phenomena commonly understood as psychiatric but may indeed be open to alternative explanations	among the Pentecostal and African churches, supernatural theodicies are deeply ingrained and that the views of the Pentecostal clergy in the current study show these to be undiminished in the UK. Additionally, while mainstream clergy tend to associate suffering with natural causes – biopsychosocial determinants – for some, the total elimination of the supernatural as an explanation for suffering remains unacceptable.
8. Magliano, L. Citarelli, G., & Affuso, G. (2021)	Views of Catholic Priests Regarding Causes, Treatments and Psychosocial	The aim of the study is to explore the views of Catholic priests	Clergy in this study are from the Catholic tradition.	Participants were asked to complete the priest version of the	The results of this study show that priests have both similarities and

	Consequences of Schizophrenia and Depression: A Comparative Study in Italy	about schizophrenia and depression in Italy	Mental illness investigated as Depression and Schizophrenia	Opinions on mental illness Questionnaire (OQ-priest) after reading a randomly chosen clinical description of either schizophrenia	differences in their views of schizophrenia and depression and their attitudes toward persons with these disorders. Priests attributed the disorder mainly to psychosocial causes and gave the lowest importance to supernatural causes. Findings highlight that persons with MDs, especially those with schizophrenia, are sometimes exposed to stigma even in religious settings.
9. Murambidzi, I. (2016)	Conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe	This study examines the clergy's conception, recognition of and responses to people with mental illnesses. The purpose of the study is to inform the	Varying denominations/Christian beliefs were represented by the clergy.	Twenty-eight in-depth interviews were conducted with clergy from ten church denominations in Harare, Zimbabwe	Mental illness was conceived as a multifactor phenomenon attributed to both natural (biological and psychosocial) and supernatural

	potential roles and contributions of the clergy to community mental health either as the only contact or as a step-in to formal mental health care.	Focused on mental illness in general	(malevolent and benevolent spiritual) causes. Spiritual factors were a dominant theme in both the clergy's views on the causes of, and in their management of mental illness. Basic mental health training was recommended by the clergy to enhance clergy capacity for mental health awareness raising, recognition of mental disorders, brief problem focused counseling, and for improving collaborative management for

					initial and continued informal and formal health care and support.
10. Stanford, M. & Philpott, D. (2015)	Baptist senior pastors' knowledge and perceptions of mental illness	The present study sought to gain a general picture of the beliefs of senior pastors within the Baptist General Convention of Texas (BGCT) about the causes and treatment of mental illness.	Christian beliefs understood in the context of the Baptist denomination. Focused on mental illness in general	Senior pastors at churches affiliated with the Baptist General Convention of Texas (BGCT) were anonymously surveyed using an online questionnaire to ascertain their knowledge and perceptions of the causes and potential treatments of mental illness	While Baptist senior pastors embraced biological causes and treatments for mental illness as most important and effective, they varied greatly across disorders as to the perceived contribution of psychosocial and spiritual factors. Senior pastors in the present study reported being open to referring their congregants to mental health care professionals with whom they shared common values
11. Yamada, A.-M. Lee, K. K. Kim, M.	Beliefs About Etiology and Treatment of Mental	This descriptive study purposed to explore pastors' beliefs about	Christian beliefs understood according to the Presbyterian tradition	This descriptive study used survey-based	Korean Presbyterian clergy tended to both

A. Moine ,M. and Oh, H. (2019)	Illness Among Korean Presbyterian Pastors	etiology and treatment of mental illness.	Focused on mental illness in general	data to compare the perceptions of Korean pastors with the perceptions of Euro-American pastors in the Protestant denomination to see whether the two groups differ in their beliefs about the etiology and treatment of mental illness.	concur and differ in their views of the etiology of mental illness. Euro-American pastors demonstrated consensus in endorsing ascribed genetic or biological factors as important causes of mental illness; they also endorsed several psychological or social factors as strongly associated with psychopathology. Korean pastors endorsed a multifactorial model of mental illness, rating many factors as important, and were more likely as a group to attribute mental illness to

		intra and interpersonal factors that may contribute to greater stigmatization of persons and families affected by mental illness.

Table 8.

Author(s); Year	Title	Code	Explanation
1. Aramouny, C., Kerbage1, H., Richa, N., **Rouhana, P., Richa1, S. (2019)**	Knowledge, Attitudes, and Beliefs of Catholic Clerics' Regarding Mental Health in Lebanon	CSD 1	Cross-Sectional Study Design 1
2. Asamoah, M. K., Osafo, J. and Agyapong, I. (2014)	The role of Pentecostal clergy in mental health-care delivery in Ghana	QL1	Qualitative 1
3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014)	Ministers_ Perceptions of Church-Based Programs to Provide Depression Care for African Americans	QL2	Qualitative 2
4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017).	Mental health literacy in religious leaders: a qualitative study of Korean American Clergy	QL3	Qualitative 3
5. Kpobi, L. N. A., & Swartz., L. (2018)	'The threads in his mind have torn': conceptualization and treatment of mental disorders by neo-prophetic Christian healers in Accra, Ghana	QL4	Qualitative 4

6. Karadzhov, D., and White, R. (2020)	Between the "whispers of the Devil" and "the revelation of the Word": Christian clergy's mental health literacy and pastoral support for BME congregants	QL5	Qualitative 5
7. Leavey, G. (2010)	The Appreciation of the Spiritual in Mental Illness: A Qualitative Study of Beliefs Among Clergy in the UK	QL6	Qualitative 6
8. Magliano, L., Citarelli, G., & Affuso, G. (2021)	Views of Catholic Priests Regarding Causes, Treatments and Psychosocial Consequences of Schizophrenia and Depression: A Comparative Study in Italy	Q1	Quantitative 1
9. Murambidzi, I. (2018)	Conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe	QL7	Qualitative 7
10. Stanford, M., & Philpott, D. (2011)	Baptist senior pastors' knowledge and perceptions of mental illness	Q2	Quantitative 2
11. Yamada, A.-M. Lee, K. K. Kim, M. A. Moine ,M. and Oh, H. (2019)	Beliefs About Etiology and Treatment of Mental Illness Among Korean Presbyterian Pastors	Q3	Quantitative 3

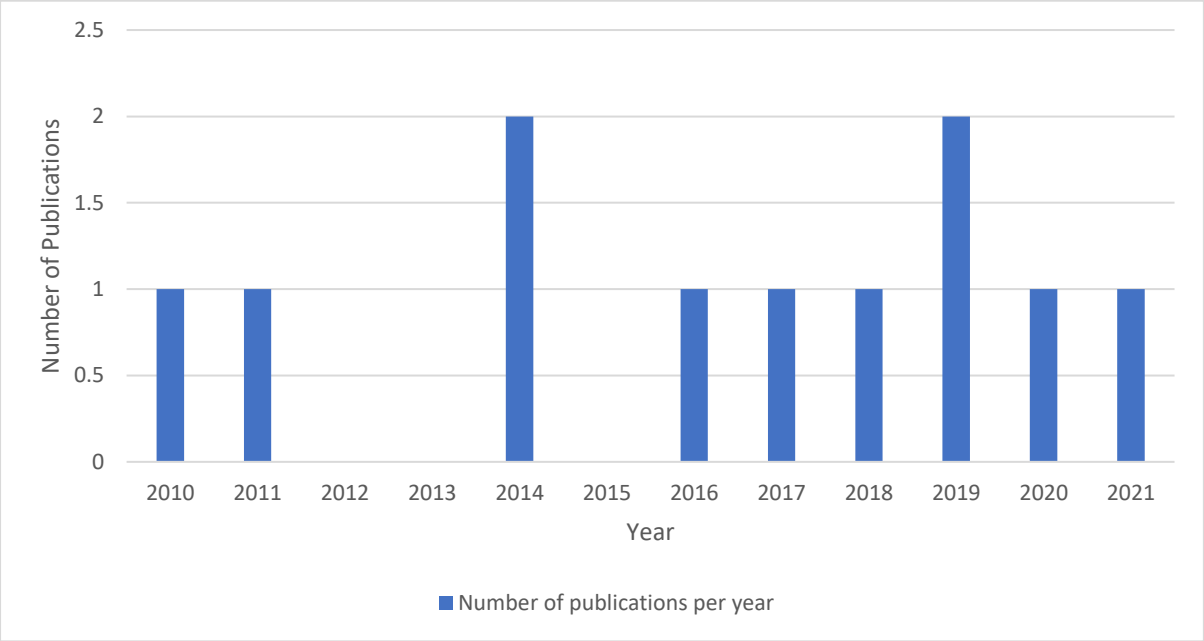
4.2.3. Description of the Results

The literature search process resulted in 11 studies being selected that met the prescribed inclusion criteria (illustrated in table 7 and 8). The resultant literature sample (n=11) is predominately composed of qualitative studies (n=7), with 3 studies subscribing a quantitative study design and one study utilised a cross-sectional design. The data collection methods for the final eleven studies that met the inclusion criteria included the following: 1) qualitative studies (semi-structured interviews and focus group interviews; 2) quantitative studies (questionnaires & surveys & 3) cross-sectional studies (combination of interview data and survey data. A majority of the studies were interested in exploring and understanding clergy's perceptions, attitudes, knowledge, views on mental illness. The clergy population is diverse across multiple demographic factors and will be later elaborated on in this section.

4.2.3.1. Number of Publications Per Year

Illustrated below in figure 3 is the distribution of the number of publications per year. There was a marked increase of studies between 2017 to 2021, highlighting that there were more studies done in latter half of the past decade. There were no studies published between the years 2012-2013 and in 2015. The most recent study was in 2021, highlighting that there are studies in this topic being currently conducted.

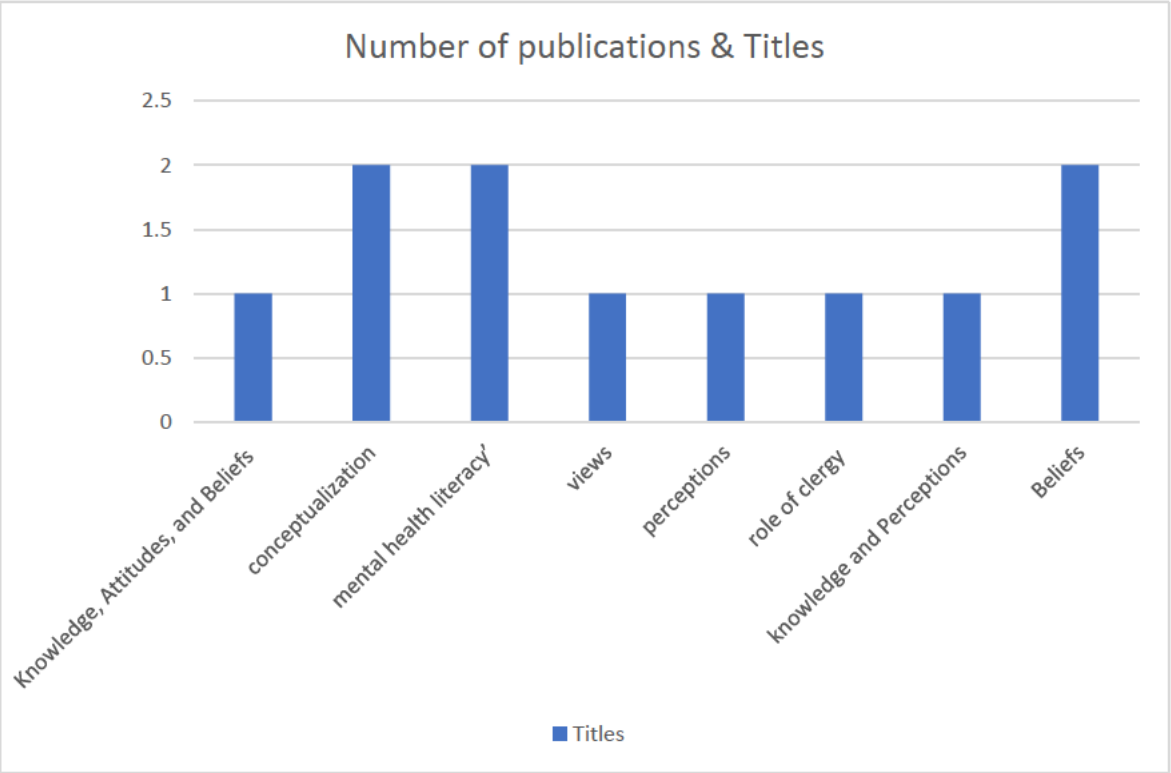
Figure 3. Number of Publications Per Year



4.2.3.2. Titles, Aims/Objectives and Conceptual Definitions of Reviewed studies

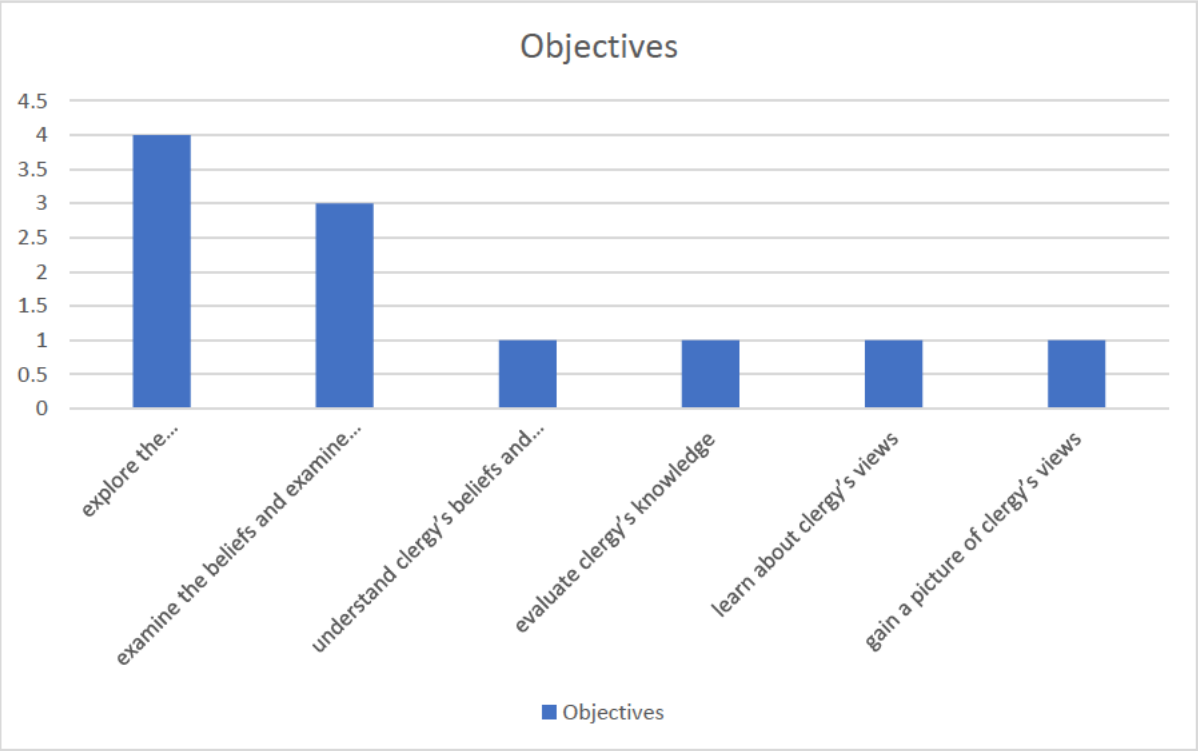
A majority of the studies have titles which are exploratory in nature and are interested in assimilating information regarding church leader's perceptions of mental health. The study titles suggest that varying studies had differing terms/subjects about mental health that were being measured or explored. The following variations in terms across the studies illustrate the variation: 'Clergy Knowledge, Attitudes, and Beliefs Regarding Mental Health', 'Clergy conceptualization of mental health disorders', 'Clergy mental health literacy', 'Clergy views of the causes of mental illness', 'Clergy perceptions of mental illness' and 'The role of clergy in mental healthcare'. The table below illustrated the prevalence of various key terms found in the titles.

Figure 4. Number of Publications & Titles



In regard to the study objectives, a majority of the studies had exploratory objectives that were aimed at gaining understanding about clergy beliefs concerning mental illness and its treatment. A majority of the studies had the objective to '*explore the perceptions/knowledge/beliefs/views of clergy'*, a few studies aimed at understanding clergy's beliefs and responses, and at '*examining the beliefs and the roles of clergy'*, while other studies aimed to '*evaluate clergy's knowledge'*, 'learn about clergy's views' and '*gain a picture of clergy's views*' about mental illness and treatment. The table below illustrates the above.

Figure 5. Objectives



4.2.3.3. Gender, national, and denominational difference of Participants

From the extensive scoping review search the total number of participants in the studies combined to a total of 1 133 participants. Across the 11 studies sampled, 2 studies did not specify 719 (64%) the Gender differences among their participant samples. Among the 9 remaining studies, there was a total of 62 (5%) female clergy and 352 (31%) male clergy, this illustrated in figure… below.

The nationality/ethnic characterisation of the participants is comprised of diverse classification of clergy's backgrounds. A large majority of the population (n= 562; 49%) reflects European Caucasians due to the extensive sampling Magliano, Citarelli, and Affuso (2021) undertook for their study. American Caucasian clergy (n= 273; 24%) were the second

largest national/ethnic group among the participants. The rest of the clergy comprised of Lebanese Arabic clergy (n= 87; 7%), Korean clergy (n= 89; 8%), Black African (n= 72; 6%), African American (n= 22; 2%), Asian (n= 4; >1%), Native American (n= 1; >1%), Hispanic (n= 10; >1%) Jamaican (n= 9; >1%), Other/Unspecified (n=4; >1%). The distribution of national/ethnic clergy backgrounds is illustrated in the figure below.

A majority of clergy across the studies are from the Catholic tradition (n= 599), this is largely influenced by the large study conducted by Magliano, Citarelli, and Affuso (2021). Presbyterian clergy also comprise of sizable portion of the clergy (n= 202). The rest of the clergy denominational are stratified as follows; Baptist (n= 168), Maronite (n= 47), Pentecostal (n= 33), Unspecified denomination (n= 58), Methodist (n= 22), Seventh-day Adventist (1), Independent (1), Indigenous Apostolic churches (n= 1), Protestant (n= 1).

Figure 6. Gender of participants

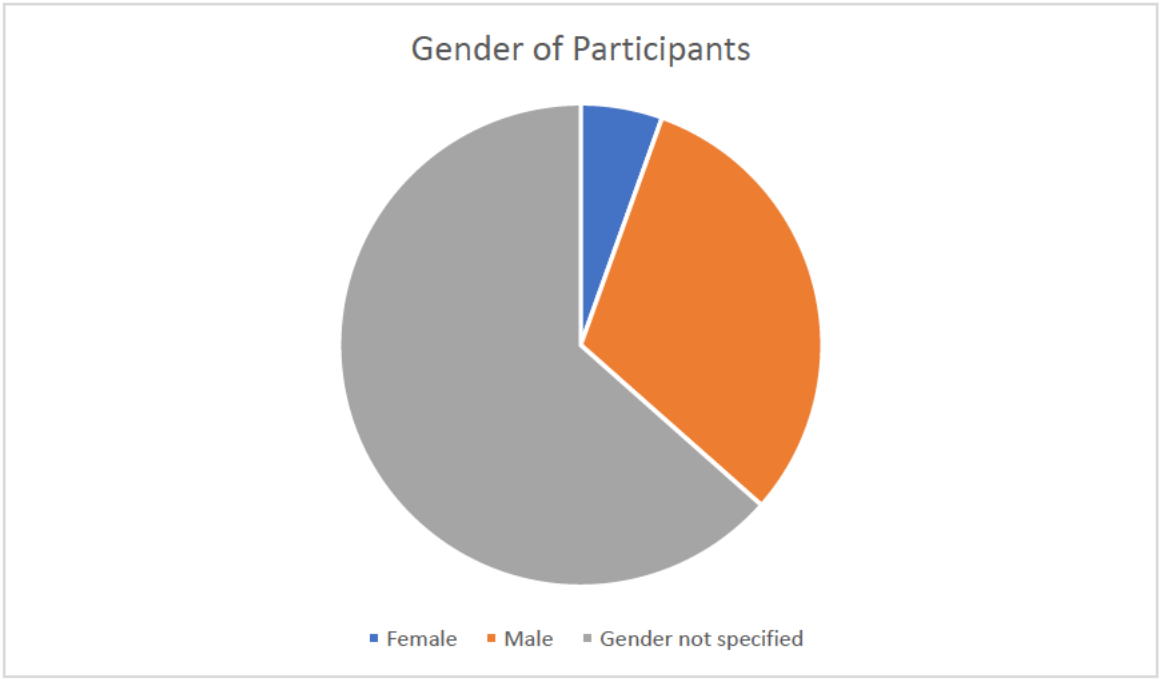


Figure 7. Clergy nationality/ethnicity

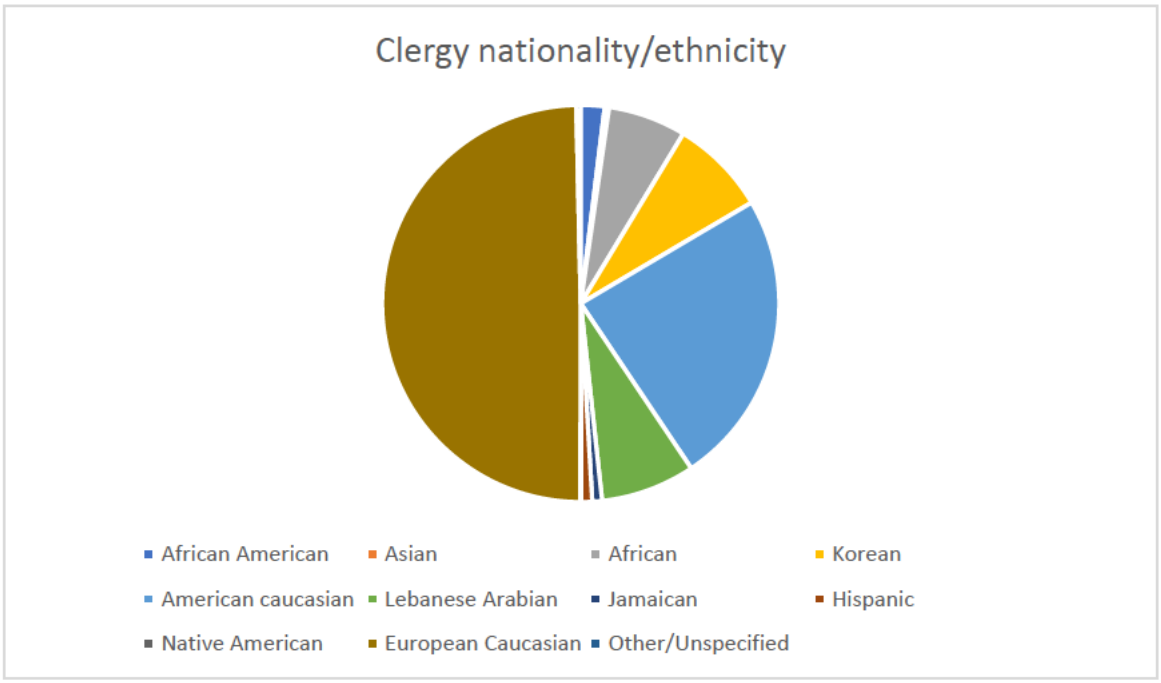
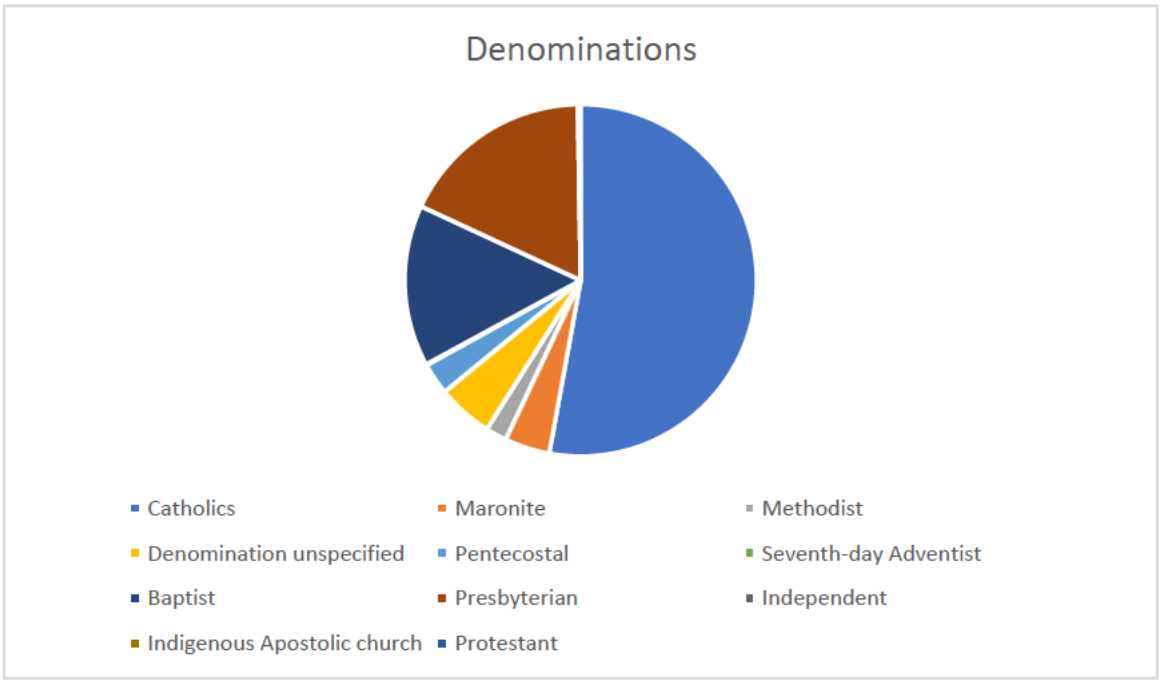


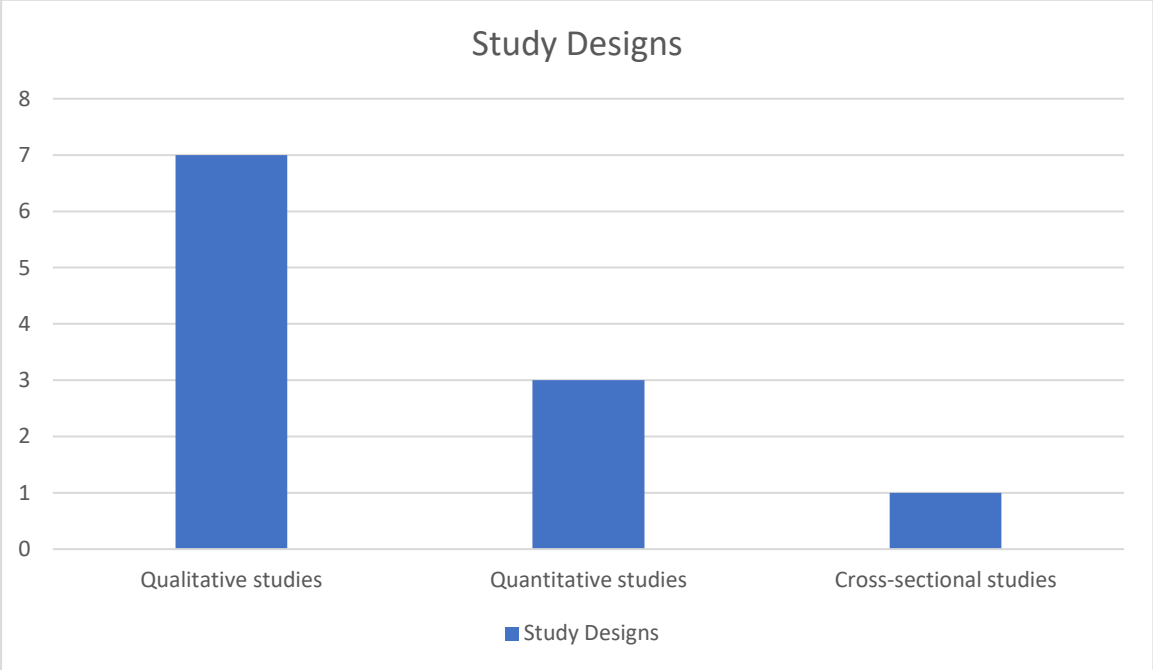
Figure 8. Denominations



4.2.3.4. Study Designs

In the relation to the study designs the results indicated that a majority of these studies used a qualitative study design (n= 7). This is reflected by the study objectives charted on figure 5, a majority of which sought to 'explore' themes around church clergy, beliefs and mental illness. Qualitative studies made use of interviews and focus groups to access rich data. The remaining studies have 3 quantitative studies and one cross-sectional study.

Figure 9. Study Designs



4.2.3.4.1 Qualitative study outcomes

Asamoah et al. (2014) (QL1) conducted interviews (face-to-face) with 20 Pentecostal clergy in Ghana to examine their role in mental health care delivery. The study found that the sampled clergy hold supernatural beliefs about the causes of mental illness, and clergy view their role in mental health delivery as specialised through providing spiritual care according to their beliefs. Another study hosted 3 focus groups for (n=21) ministers to understand their views on mental illness and the feasibility of establishing church-based programmes to care for African American members living with depression (Hankerson et al., 2014) (QL2). Results

from the study suggest that clergy understand depression among African American's as stemming from social and economic inequalities, clergy in the study were willing to implement church-based programmes for mental healthcare. Jang et al. (2017) (QL3) individually interviewed 17 Korean American clergy in attempt to explore their held beliefs and knowledge about depression, the study found that clergy hold religious explanations about the origin of depression, the study also identified the need for mental health education, this need is evident due to stigmatising beliefs held by clergy. In Kharadzova and White's (2016) (QL4) study exploring the mental health literacy of Glasgow clergy, results from the interviews highlight that clergy conceptualise mental illness according to the biopsychosocial understanding. Clergy in the study encourage referral of mental health patients and are able to incorporate their spiritual beliefs alongside other models of mental illness. One study which investigated neo-prophetic Ghanaian clergy's conceptualisation and treatment of mental illness found that these clergy largely uphold spiritual beliefs about mental illness and have a limited scope on mental health knowledge and favour spiritual treatments of mental illness, however these clergy were open to referring mental health patients (Kpobi, & Swartz, 2018) (QL5). Leavey (2010) (QL6) investigated UK based clergy to understand their reaction to mental illness among their congregants by conducting interviews with 19 clergy men, the results show that disparities about beliefs existed between Pentecostal/African clergy and mainstream (Anglican and Catholic) clergy, these beliefs have implications on treatment options and referrals. Also, Murambidzi (2016) (QL7) investigated the conceptualisation of mental illness among clergy in Harare, Zimbabwe. The study found that clergy still rely on spiritual models to understand mental illness and its treatment, however some are aware of the multiple factors involved in mental illness, the study suggests that clergy need mental health education due to their crucial role in the well-being of the congregants.

4.2.3.4.2. Quantitative study Outcomes

Magliano et al., (2021) (Q1) explored the views of Italian Catholic clergy about depression and schizophrenia. After reading the participants were provided with the Opinions on mental illness Questionnaire (OQ-priest) which assessed their views about either depression or schizophrenia, there were notable differences on opinions concerning both mental illnesses, these differences were undergirded by varying demographic factors. In Stanford and Philpot's (2015) (Q2) study, Baptist pastor's beliefs and knowledge about mental illness and its treatment were investigated using an online questionnaire. The study results suggested that pastors hold a modern scientific view of mental illness and are actively engaging in mental health referral. A descriptive study explored Korean and Euro-American Presbyterian clergy's beliefs about the causes and treatment of mental illness by providing clergy with surveys (Yamada et al., 2018) (Q3). Their findings found statistically significant differences between Korean and Euro-American Presbyterian clergy's models of mental illness, with Korean clergy endorsing more spiritual explanations and Euro-American mostly endorsing biological models.

4.2.3.4.3. Cross-sectional study outcomes

Aramouny et al., (2019) (CSD1) investigated the knowledge, attitude and beliefs of Catholic clerics regarding mental illness. Clerics were given a questionnaire during a 30-minute interview which assessed their knowledge and attitudes about mental illness. The study found that clerics see that mental illness emerges from psychosocial factors and substance misuse, surprisingly, few clerics mentioned religiosity/spirituality. However, stigmatising beliefs about mental illness and its treatment were identified among clerics.

This study identified that most studies conducted in relatively low-income settings had a qualitative study design, with quantitative/cross-sectional studies being conducted in relatively middle to high income settings. This difference may be related to the contrast in

availability of resources to conduct extensive research. Qualitative studies are often cheaper to conduct in comparison to quantitative studies which require ample time, data analysis tools, and access to large population samples (Runciman, 2002). Relatively few studies (N=3) that were from African countries were qualitative in design whilst all quantitative and cross-sectional studies were conducted in America or Europe (N=7). The resource gap between historically wealthy countries and underdeveloped countries may have a role in the types of studies that can be conducted in various spaces. This may imply that there is a limit in the types of knowledge available on clergy's representation and treatment of mental illness, the current study highlights this gap of quantitative studies, which may be indicative of a lack of resource availability In addition to the lack of studies investigating clergy's conceptualisation and treatment of mental illness, the types of research conducted in this topic, particularly in African countries, are limited, indicating that this research topic has not been widely researched.

4.2.3.5. Summary of outcomes

The results from the studies (n= 11) suggest that clergy have various conceptualisations of mental illness that are associated with a variety of outcomes. These outcomes reflected in studies CSD1, QL2, QL5, Q1 and Q2 demonstrated that clergy adopted predominantly a Biopsychosocial Model (explanatory model) in conceptualizing mental health, with some clergy (n=835) placing greater emphasis on biomedical and psychological factors as causes of mental illness. The clergy that adopted Biopsychosocial Model as an explanatory model for mental illness were mainly from a Western background or context, with these studies predominantly being conducted in this context. Specific to this sample, spiritual explanations of mental illness were avoided or used to further contextualise mental health related issues, however their religious beliefs appear to play a less significant role than Western Biopsychosocial Models. Clergy that adopted Western understandings of mental illness promoted Western Biomedical explanatory/treatment models and their respective interventions

(i.e., psychiatric/medical) treatments and often readily refer church members when necessary. Some of these clergy rely on their educational backgrounds to aid their knowledge of mental illness and treatment. Also, clergy use religious frameworks to explain issues such as drug and alcohol abuse or other behaviour that is can be seen as not morally appealing.

Outcomes from the studies QL1, QL3, QL4 and QL7 indicated that clergy participants adopted supernatural explanations of mental illness, while the studies QL6 and Q3 engaged in a comparative analysis between clergy that hold supernatural and Western conceptualisations of mental illness. Clergy from the studies mentioned above who hold supernatural explanations of mental illness are mainly from non-Western settings or backgrounds such as Africa and Korea. The studies observed that these clergy use their supernatural beliefs to frame their treatment of mental illness, with some clergy trusting their laurels as spiritual healers to treat vulnerable church members, these treatments can involve prayer, exorcism, bible reading and pastoral counselling. The outcomes of studies QL1, QL3 and QL7, which were in African countries, suggest that perpetuating socio-economic factors limit one's access to mental healthcare practitioners, thus making clergy-based intervention more viable/available. Their reliance on spiritual models and treatment are not only based on their spiritual beliefs but are also mediated by difficulty in accessing formal health care, particularly in low-oncome settings. Evidence from the studies suggests that the types of explanatory models used by clergy appear to be influenced by their socio-cultural backgrounds which inform their epistemic positions around beliefs and understandings about mental illness. Finally, the study by Yamada et al. (2018) (Q3) highlights the difference between clergy from Western and non-Western backgrounds, Euro-American clergy subscribed to Western models of mental illness while Korean clergy frame mental illness according to religious/spiritual explanations. This suggests that socio-cultural contexts and ethnic backgrounds can have an implication on the models of mental illness that clergy hold.

4.2.3.6. Limitations of studies

The scoping review search process yielded (n= 11) studies which met the inclusion criteria necessary for this study. However, a majority of the sampled studies were completed in first world countries (i.e., United States, England, Scotland, Italy) and the evidence available for this scoping review mainly reflect the representations of clergy that exist in Western societies. This suggests that there are a few studies of this scope which are being conducted in non-Western societies, this is important as religion and Christianity in particular, is experienced in uniquely across cultures and ethnicities. This limitation hampers the opportunity to involve different narratives while mapping the existing evidence on the perceptions of clergy on mental illness and remediation. The scoping review was able to access a few studies which were conducted in Africa however these studies were in only two countries (Ghana and Zimbabwe), this highlights that there is not much variability of studies in African contexts that focus on this topic. There exists an estimated 600 million people in the African continent who are Christian, and Africa is expected to become the next 'global centre' of Christianity, therefore studies that investigate the beliefs and roles of clergy in mental healthcare may become of greater interest and necessity in this context (Johnson et al., 2017; Kazeem, 2019).

4.3. Discussion of Results

4.3.1. Introduction

The scoping review search process resulted with (n=11) studies being selected after meeting the inclusion criteria. What is evident in the outcomes of the studies are the variability of clergy's perception based on various contextual factors such as ethnicity/nationality, socio-cultural background, denominational affiliation, and exposure to persons with mental illness.

4.3.2. Participant, Concept and Context of Reviewed Studies

As mentioned in the previous section, most of the reviewed studies were conducted in Western countries (i.e., USA, UK, and Italy) thus the review contains a significant narrative from clergy that exist in developed Western nations. These developed countries are marked by economic and industrial advancements, stable social conditions, and Western modernisation, all of which shape the socio-cultural landscape (Jeníček, 2011). The higher number of Western-based studies may reflect the obvious advantages these societies enjoy compared to developing and underdeveloped societies, and due to these historical differences in resources the research gap continues to exist between the global north and global south (Yazid et al., 2014). This research gap elucidates the disparities that exist in mental healthcare between Western and non-Western societies (WHO, 2010). Coincidentally non-Western developing countries have proportionately greater need for mental healthcare research and delivery due to the mental health crisis that exists in these societies (Macintyre et al., 2018). However, among the studies conducted in Western developed societies, a few studies (QL2, QL3, QL5) focus their attention on minority groups and clergy (i.e., African Americans, Africans in the UK and Korean Americans). There appears to be a current interest in clergy from previously disadvantaged communities and their engagement with mental healthcare.

There still exists gaps in the development of studies in developing societies in comparison to developed ones which may be reflective of the disparities of mental healthcare in general. However, studies in developed societies are giving account to minority groups which reflects a burgeoning interest in clergy that exist in these communities.

The search process yielded mostly qualitative studies (n= 7) which are interested in gaining understanding and subjective meaning, the prominence of qualitative studies may highlight the need for researchers around this topic to engage extensively with clergy's deeply held beliefs about mental illness and its treatment. The study objectives of the reviewed articles show that most of the reviewed studies aimed to "*explore the perceptions/knowledge/beliefs/views of clergy*" or "*Examine the beliefs and roles of clergy*" which highlights a significant interest in clergy's subjective understandings of mental illness. The propensity for researchers to seek insight into subjective representations of mental illness signifies a need to understand their beliefs/perceptions in a manner that accounts for subjective and socially constructed meanings.

However, only a few of the reviewed studies (Q1, Q2, and Q3) were quantitative and interested in the generalisability of data. Quantitative research provides evidence that has statistical support, empirical and generalisable, which allow for scientific rigour. The lack of these studies in the reviewed articles implies that the evidence that is extracted cannot be viewed as having generalisable applicability across the research on this topic. Christianity is found across multiple societies and investigating clergy's beliefs and treatment of mental illness would require extensive evidence that would be generalisable. Improving mental healthcare delivery may be boosted by the increased interest in clergy and their roles in mental health, research in this area can assist bolster task shifting through engagement with the Christian church.

Reflection on the evidence above highlights the gap in the literature of studies around clergy's beliefs and treatment of mental illness, this shows the need for: 1) Increased research in non-Western developing countries, particularly South Africa, 2) Further quantitative studies that provide quantifiable and generalisable evidence of clergy's beliefs and knowledge of mental illness and its treatment. The information above suggests that there is a wide gap of literature broadly and yet there is a need to engage more in-depth with the topic. Attempting to understand clergy's beliefs and treatment of mental illness is a task that requires modes of research which investigate both subjective, laden, and quantifiable data (i.e., mixed-methods approach).

As illustrated in Figure 7, a large majority of the participants (75% of all participants) across the reviewed studies were White European or American clergy, the rest of the church leaders involved were African America, Asian, Black African, Korean, Lebanese, Native American, Jamaican and Hispanic. It was elucidated upon that a majority of the studies stem from Western developed societies and the large number of participants are represented by White European or American clergy, suggesting that a large narrative of the evidence be reflective of particular constituency of clergy. Though there exists a variety of clergy in the studies, they are proportionately smaller than White European or American clergy. It is interesting to note that the large-scale quantitative studies were conducted in Western developed societies had a large majority of White European or American clergy, while a majority of qualitative studies constituted of non-Caucasian clergy from non-Western societies. It appears that large scale quantitative studies that require extensive access to resources and participants are mainly being completed in Western communities, highlighting the resource and research gap that exists between Western and non-Western societies. The evidence that emerges from the scoping review may not be reflective of a broader narrative on clergy's

beliefs and perceptions of mental illness and its treatment due to the nature of literature available on this topic.

The review process did not yield any South African articles or literature which highlights a significant gap of research on clergy's beliefs and treatment of mental illness. Christianity has a significant following in South Africa (an estimate of 84% South Africans are practicing Christians) and has become deeply ingrained in its communities, to the extent where African cosmology and Christianity have been enmeshed together to produce belief systems that resonate with many South African cultures and people today (Schoeman, 2017; Erlank & Cabrita, 2018). It is estimated that only 25% of South Africans who have experience mental illness may receive mental health care, yet multiple studies suggest that a significant number of South Africans readily consult traditional and religious leaders for mental health treatment (Petersen et al., 2016; Babb et al., 2007; Zingela et al., 2018). Nxumalo et al. (2011) suggest that the use of traditional and religious healers in South Africa is more common among persons who may not be able to afford or access formal mental healthcare, implying that a considerable number of South Africans rely on traditional/faith-based healers for mental health. Involving traditional healers and religious leaders in mental health treatment can be integral in accessing communities and people who may otherwise not be access formal mental health services.

However, the gap in research investigating church clergy's representation and treatment of mental illness becomes increasingly glaring when we consider the mental health treatment gap and the prominence of traditional healers and/or faith healers in South Africa. Investigating Christian clergy's representation and treatment of mental illness offers insight that can foster understanding and encourage platforms for collaborations between the Christian church and formal mental health services. Van Niekerk et al. (2014) suggest that there exist various degrees of suspicion between formal mental health practitioners and traditional healers and/or faith-

based healers, the fracture between these parties is not beneficial, especially for mental health care users in South Africa. The attempt to bridge the mental health care treatment gap in South Africa should involve increased research on the role Christian clergy have in mental healthcare due to the wider societal implications this strand of research holds.

Christianity is comprised of a multiplicity of denominations that exist in various cultural contexts. Within Christianity, denominational differences often are based on differences in theological beliefs, practices and cultural re-interpretations. In the study a variation of Christian denominations was represented by clergy participants. A majority of the participants (84% in total) were Catholic, Presbyterian and Baptist, these denominations have a considerable following among Christians worldwide.

The current study searched for studies investigating church leader's representation of how Christian beliefs inform mental illness identification and remediation (referral pathways) in vulnerable church members, this process yielded 11 publications that met the criteria. The study results are reflective of what the literature (chapter 2) says about this topic, however the findings lend a greater focus towards a contextualised view of clergy's representation and treatment of mental illness. The analysis of the study results presented 4 themes that observed across the studies: 1) Clergy's conceptualisation of mental illness, 2) Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways) 3) Influence of the socio-cultural context, 4) Study Recommendations. These themes will be further discussed below.

4.3.3. Clergy's conceptualisation of mental illness

Table. 9

Clergy's conceptualisation of mental illness

Clergy's conceptualisation of mental illness	Source
Influence of Biopsychosocial Conceptualisation of Mental Illness	1. Aramouny, C., Kerbage1, H., Richa, N., Rouhana, P., Richa1, S. (2019), 3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014), 4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017)., 5. Karadzhova, D., & White, R. (2016)., 7. Leavey, G. (2010), 8. Magliano, L. Citarelli, G., & Affuso, G. (2021), 10. Stanford, M. & Philpott, D. (2015), 11. Yamada, A.-M. Lee, K. K. Kim, M. A. Moine ,M. and Oh, H. (2019)
Supernatural Influences on mental illness	2. Asamoah, M. K. Osafo, J and Agyapong, I. (2014), 6. Kpobi, L. N. A., & Swartz., L., 7. Leavey, G. (2010), 9. Murambidzi, I. (2016), 11. Yamada, A.-M. Lee, K. K. Kim, M. A. Moine, M. and Oh, H. (2019)

The first theme identified during the review process was clergy's conceptualisation of mental illness. The theme is separated into two categories: Influence of Biopsychosocial Conceptualisation of Mental Illness and Supernatural Influences on mental illness. Clergy's representation of mental illness across the publishments highlights that clergy are drawn

towards conceptualisations that fit their immediate context. Various clergy adopt the Biopsychosocial Models of mental illness which reflect the Westernised contexts these clergy exist in. Clergy from non-Western contexts appear to adopt supernatural beliefs about mental illness, which complement their socio-cultural context. There is some cognitive tension observed among clergy that have adopted modern understandings of mental illness and yet maintain that spirituality has a role in mental illness. The tension and polarity that exists between these models reflects the complex involvement of socio-cultural contexts in contemporary times.

4.3.4. Influence of Biopsychosocial Conceptualisation of mental illness

The evidence from the reviewed studies indicates that a considerable number of clergies have adopted the Biopsychosocial conceptualisations of mental illness to conceptualise mental illness in their vulnerable congregants. The Biopsychosocial Model of mental illness has become a popularised and widely accepted model to represent mental health development and treatment (Lehman et al., 2017). This approach towards mental illness conceptualisation is marked by scientific modernisation and which characterises multiple Westernised contexts (Bolton & Griffin, 2019). Among the participants in the reviewed studies, a considerable number of clergies adopt the Biopsychosocial Models of mental illness. However, clergy vary on what aspects of biological, psychological and social factors that are deemed more pertinent than others, and some attempt to combine them with spiritual beliefs.

Certain studies found that the clergy in their research adopt the basic premise of the Biopsychosocial Model to explain mental illness and depression (Aramouny et al., 2019; Karadzhova, & White, 2016; Magliano et al., 2021; Stanford, & Philpott, 2015). Studies that suggest clergy use Biopsychosocial conceptualisation of mental illness highlight that clergy's exposure to vulnerable congregants and socio-cultural influences can inform their

conceptualisations of mental illness. Aramouny et al. (2019) (QL1) found that among the Lebanese clerics in their study, their conceptualisation of mental illness is influenced by their exposure to vulnerable congregants and education on mental health. Karadzhova and White (2016) (QL4) noticed the influence of their participants broader Western, Eurocentric socio-cultural environment and education as factors that have shaped their adoption of biopsychosocial conceptualisation of mental illness. Magliano et al. (2021) (Q1) state that the impacts of modernisation may have an influence on their clergy participants adoptions of Biopsychosocial Models, also social representations have bearings on commonly held beliefs of mental illness. Baptist clergies were found to hold 'mainstream' beliefs about mental illness which imply the Biopsychosocial Model of mental illness, these clergy were aware of various aspects of mental illness due to exposure with mentally ill members (Stanford, 2010) (Q3). The study by Leavey (2010) (QL6) found that among their clergy participants, mainstream clergy promoted the Biopsychosocial Model and completely rejected supernatural explanations of mental illness. In their study comparing Korean and Euro-American clergy's beliefs about mental illness, Yamada et al. (2019) (Q3) found that Euro-American clergy placed importance on biological factors and also acknowledged the influence of psychosocial factors on mental illness. The evidence suggests that clergy that conceptualise mental illness using the Biopsychosocial Model gain their reference from Westernised, scientifically based beliefs about health psychology.

The evidence suggests that certain clergy that conceptualise mental illness according to Biopsychosocial conceptualisation appear to distance themselves from supernatural explanations that are prevalent in Christianity. In the study conducted by Aramouny et al. (2019) (CSD1) their results contradicted their hypothesis as they found that Lebanese clerics eschew supernatural explanations of mental illness in favour of modern explanations. Participants that adopted modern conceptualisations of mental illness viewed supernatural

explanations as irrelevant and counterproductive, some clergy distinguished themselves from 'typical African pastors' who use supernatural explanations of mental illness (Karadzhov & White, 2016) (QL4). Magliano et al. (2016) (Q1) found in their study that clergy gave supernatural explanations the lowest importance in understanding mental illness. Denominational affiliation can be a contributing factor towards the attitude some clergy hold about the importance of spiritual factors on mental illness. This can combine with overarching impact of Westernisation to shape a certain proportion of clergy's held beliefs about mental illness. Supernatural beliefs about mental illness are not favourable among clergy of denominations that follow Westernised principles of living.

The study observed that some clergy participants hold both Biopsychosocial Models of mental illness with supernatural beliefs. In their study, Karadzhov and White (2020) (QL4) saw that a few clergy are willing to consider spiritual issues even when they adopt biopsychosocial conceptualisations of mental illness, they state that this is seen where clergy are characterised by religious and cultural pluralism. Stanford and Philpott (2011) (Q2) highlight that Baptist clergy in their study mainly adopt biopsychosocial beliefs about mental illness however they include spiritual beliefs when engaging persons with depression or anxiety. For clergy that exist in multi-cultural contexts their beliefs about mental illness may be more 'fluid' and incorporate natural and supernatural conceptualisations

The common expectation that religious leaders may prefer spiritual explanations of mental illness appears to be an overgeneralisation. It has been illustrated above that clergy's socio-cultural context and denominational affiliation have an impact on their conceptualisation of mental illness. Clergy that adopted Supernatural beliefs about mental illness occur in specific contexts that can shape their conceptualisation of mental illness.

4.3.5. Supernatural Influence of mental illness

Across the reviewed studies, Supernatural beliefs about mental illness were adopted by certain clergy participants and appeared to also be influenced by socio-cultural factors. Christianity is often synonymous with spiritual beliefs about existence and reality, and it is expected that Christian beliefs about mental illness will follow this premise (Zagożdżon, & Wrotkowska, 2017). Supernatural beliefs about mental illness in Christianity have historically been controversial and are at times deemed to play a role in influencing stigmatising beliefs (Wesselmann & Graziano, 2010). Unlike the Biopsychosocial conceptualisation of mental illness, the current study noticed that spiritual beliefs of mental illness are promoted by clergy from non-Western contexts.

Asamoah et al. (2014) (QL1) found that Pentecostal clergy in their study hold spiritual beliefs about mental illness that match culturally held beliefs mental illness in Ghana. All forms of suffering or distress are understood as caused by diabolical forces, witchcraft or sinful behaviour. Kpobi and Swartz (2018) (QL4) noticed that clergy in their study see mental illness to be influenced by evil spirits or a consequence of sinful behaviour. In this study clergy's ideas about mental illness were limited to psychotic disorders which may reinforce their supernatural beliefs about mental illness due to the spiritual characterisation of psychosis in many African cultures. However, clergy in this study acknowledged that mental illness can be caused by various other factors namely drug or alcohol misuse and brain injuries from accidents, but spiritual explanations were given greater adherence. Jang et al. (2017) (QL3) found that Korean American clergy in their study conceptualise depression according to religious based perspectives, suggesting that appropriate 'religious' behaviour mediates the presence of mental disorders. In a study investigating the conceptualisations of mental illness by clergy in Harare, Zimbabwe, spiritual explanations of mental illness, these results also mimicked the cultural context clergy exist in (Murambidzi, 2016) (QL7). In Leavey's (2010) (QL6) study, they

noticed that African Pentecostal clergy proposed supernatural explanations of mental illness and moral shortcomings which need spiritual treatment. Korean clergy compared to Euro-American clergy were found to favour psychosocial and spiritual factors as causes of mental illness, placing less importance on biological factors when compared to Euro-American clergy (Yamada et al., 2019) (Q3). The findings from these reviewed studies corroborate with previous literature (cited in the literature review chapter) that investigated the role of spiritual beliefs in conceptualisations of mental illness (Mathison and Wade, 2009; Wesselmann & Graziano, 2010; Behere, Das et al., 2013; Moreira-Almeida et al., 2014; Stanford, 2007; Okasha & Okasha, 2012).

Across the reviewed studies, clergy that hold Supernatural Models to explain mental illness mainly exist in non-Western contexts and cultures acknowledge the role of non-corporeal agents on lived experiences. African cosmology across multiple cultures is premised on the belief that supernatural agents share a symbiotic relationship with the physical world (Kruger, 2012). Also, various culturally based beliefs about mental illness are similar to Christian spiritual beliefs such as beliefs in malignant spirits, consequences of sin/culturally inappropriate behaviour and witchcraft (Dein, 2020). Clergy from Pentecostal and neo-prophetic denominations were observed to comprise the majority of participants who endorse spiritual models. Clergy participants from the studies conducted in African countries (Asamoah et al., 2014; Kpobi and Swartz, 2018; Murambidzi, 2016) (QL1, QL4, and QL7) exist in such contexts which may be influential in their conceptualisation of mental illness. Yamada et al. (2019) (Q3) state that the 'cultural scripts' that pervade Korean clergy's contexts can influence their perceptions and views of mental illness. Jang et al. (2017) (QL3) refers to the Korean immigrant community and their cultural beliefs as factors that can influence clergy's perceptions and role in mental health. Supernatural beliefs about mental illness appear to

resonate better with clergy from non-Western settings whose cultures are more a-kin to spiritual explanations.

Some studies indicate that clergy participants who adopted supernatural explanations of mental illness do acknowledge the role of biopsychosocial factors on the presence of mental disorders. In this study the Korean clergy were seen to mainly have a multi-factoral approach to understanding mental illness (Yamada et al., 2019) (Q3). Murambidzi (2016) (QL7) noticed that the clergy sample acknowledged the impacts of issues such as brain damage, poverty and trauma, however they mainly referenced drug abuse as the most common referenced natural cause of mental illness. Participants in Kpobi and Swartz (2018) (QL4) study also acknowledge that other factors other than spiritual forces influence mental illness, clergy in the study cite drug/alcohol abuse or traumatic brain injury. The studies suggest that clergy in the above studies may state that alcohol and drug use are factors in mental illness as a resultant of morally deviant behaviour, reinforcing stigma (Kpobi & Swartz, 2018; Murambidzi, 2016) (QL4 and QL7). Asamoah et al. (2014) (QL1) found that clergy in his study saw Biomedical Models as only pertaining to specific mental health conditions however they believed that there are mental illness that cannot be explained naturally and need their specific treatment. Among the clergy that promoted supernatural explanations of mental illness the evidence suggests that they are still tendencies to include religious values and distinguish natural from supernatural mental illness traits (Asamoah et al., 2014; Kpobi & Swartz, 2014) (QL1 and QL4). Similar to clergy participants who subscribe to the Biopsychosocial conceptualisations of mental illness, clergy mentioned above appear to distinguish supernatural conceptualisation of mental illness from the modern models, this highlights a possible dichotomy of these two perspectives. This dichotomy appears to be underpinned by socio-cultural and denominational differences among clergy participants.

The current study earlier elaborated in the literature review on the relations that Supernatural conceptualisations of mental illness have with stigmatising beliefs. There are certain Christian beliefs around the causes of mental illness such as references to moral failing/sin, presence of malevolent spirits and witchcraft have been observed to shape stigmatising narratives about persons living with mental illness (Wesselmann and Graziano, 2010). The reviewed studies observed the presence of stigmatising beliefs among their clergy participants, particularly among clergy that hold to Supernatural conceptualisation of mental illness. Findings from Kpobi and Swartz (2018) (QL4) indicate that the supernatural beliefs held among the Pentecostal clergy can foster stigma, as mental illness can often be blamed on an individual or their surrounding context. Asamoah et al. (2013) (QL1) corroborates this sentiment as they observed that clergy were aware of the stigmatising nature of their Supernatural conceptualisation as they can produce *social stigma* and *abuse of mentally ill persons*. The presence of stigma among clergy was observed also in the following studies: QL3, QL5, QL6, Q1, and Q3. These stigmatising beliefs may occur due to the nature of Supernatural beliefs of mental illness however stigma may be influenced low levels of mental health literacy, scarcity of mental health resources and broader socio-economic factors that limit access to mental health services (Wesselmann and Graziano, 2010).

This theme addressed study present study's objectives to explore existing evidence of church leader's perception of mental illness and understand how Christian beliefs inform perceptions of mental illness. The evidence above suggests that church clergy's perceptions of mental illness are split between the Biopsychosocial and supernatural conceptualisations of mental illness. Their socio-cultural context plays a role in their perceptions of mental illness while their Christian beliefs may have greater influence when they hold Supernatural Models of mental illness.

4.3.6. Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways)

Table. 10

Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways)	Source
	1. Aramouny, C., Kerbage1, H., Richa, N., Rouhana, P., Richa1, S. (2019); 2. Asamoah, M. K. Osafo, J and Agyapong, I. (2014); 3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014); 4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017); 5. Karadzhova, D., & White, R. (2016) 6. Kpobi, L. N. A., & Swartz., L., 7. Leavey, G. (2010); 8. Magliano, L. Citarelli, G., & Affuso, G. (2021); 9. Murambidzi, I. (2016); 10. Stanford, M. & Philpott, D. (2015); 11. Yamada, A.-M. Lee, K. K. Kim, M. A. Moine, M. and Oh, H. (2019)

The second theme identified in the review studies is the 'Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways)', across the reviewed studies the evidence suggests that clergy see their roles mainly involving spiritual and psychosocial care. However, the roles and remediation pathways clergy engage in are impacted by their conceptualisation of mental illness, socio-cultural context and access to formal healthcare. The evidence from the studies suggests that clergy are increasingly

aware of the role of mental health practitioners and are willing to engage in referrals for congregants, however, this can be mediated by spiritual/religious values and perception of formal mental health practitioners and treatment.

Stanford and Philpott (2015) (Q2) study saw that Baptist clergy saw their role as providing spiritual care (faith-based counselling) particularly for congregants with mental disorders clergy deem stem from psychosocial-spiritual causes. The study however did recognise that clergy may overgeneralise psychosocial-spiritual causes of disorders such as depression and anxiety and lead to inconsistent referral of vulnerable members (Stanford & Philpott, 2015) (Q2). Clergy referrals were also impacted by their religious beliefs as most clergy expressed that they mostly refer to practitioners whom they know to share similar values (Stanford & Philpott, 2015) (Q2). In the study conducted by Magliano et al. (2021) (Q1) priests separate their role in mental health treatment from that of formal practitioners and see their role to involve spiritual and psychosocial support of congregants. In line with their conceptualisation of mental illness, priests in the study do not retain services of exorcists but are seen to readily refer congregants to relevant mental health practitioners (Magliano et al., 2021) (Q1). However, this may vary across disorders depending on the importance placed on biological or psychosocial-spiritual factors that influence mental illness.

Clergy in Karadzhov and White (2016) (QL5) defined their roles in mental healthcare of congregants as one in which they provide '*holistic, non-directive, low intensity pastoral care'*, these clergy use their modern multi-factoral beliefs about mental illness as a basis for their roles towards congregants. The participants used their knowledge of psychological disorders and prior education to rationalise their consistent referrals to mental health practitioners. Participants in the study engage in prayer as a form of treatment however this is used alongside formal mental healthcare.

Hankerson et al. (2013) (QL2) found that ministers in the study viewed their role as spiritual advisors who offer counselling according to faith principles, however these clergy encourage referral to mental health services. Ministers in the study state that a lack of resources and time constraints hampered their ability to provide more comprehensive care and make referrals to adequate health services, at times these ministers could only rely on providing spiritual treatments and social support. Leavey (2010) (QL6) observed that mainstream clergy, who mainly adopt Biopsychosocial conceptualiastions of mental illness, still include spiritual explanations of mental illness so to be involved in the treatment process. However, the study suggests that these clergy can be conflicted about their treatment options since endorsing the Biopsychosocial conceptualisation implies that using spiritual treatment (e.g. prayer and exorcism) may be discouraged, yet it's the spiritual treatments that 'legitimise' their role in the treatment of vulnerable members (Leavey, 2010) (QL6).

The above studies mainly portrayed clergy participants who adopted Biopsychosocial conceptualisations of mental illness. The evidence highlights that modern, mainstream clergy from Western background still reference spiritual factors in mental illness to make visible their role as spiritual advisors or counsellors. Clergy see their role specialised towards providing psychosocial and spiritual care that is represented through spiritual counselling and emotional care for congregants. Their conceptualisation of mental illness may change across disorders in which they perceive to have influential roles, also, socio-cultural representations of disorders such as depression and anxiety may impact their perceived roles (Magliano et al., 2021) (Q1). Clergy that adopt Biopsychosocial conceptualisations of mental illness may experience conflict in their roles in the treatment of vulnerable members since their religious beliefs may require them to provide spiritual care, which can be shunned in Western contexts that largely condone secular treatment. Access to mental health resources can impact the treatment options that

clergy have for vulnerable members, this may limit clergy to provide spiritual and psychosocial care for members.

In the study done by Jang et al. (2016) (QL3) clergy recognise their role as servicing congregants with spiritual help and providing vulnerable members with referrals options for mental healthcare. These clergy mainly emphasised spiritual treatments for depression as this was their common mode of treatment, also, clergy rely on providing spiritual treatment due to the perceived lack of adequate mental health resources aimed at immigrant Koreans (Jang et al., 2016) (QL3). Clergy sampled in Harare, Zimbabwe saw their role as collaborative and complimentary to the overall mental health of congregants, clergy also saw their role as raising mental health awareness, addressing stigma, providing crisis support and counselling (Murambidzi, 2016) (QL7). However, clergy in this study state that these roles are hampered due to a lack of resources and access to formal health care for congregants, this means that clergy are at times required to extend beyond their capabilities to service congregants, and often need to rely on their spiritual expertise and treatments to provide help (Murambidzi, 2016) (QL7). A lack of adequate resources and access to mental health services appears to have a role in the treatment options that clergy from non-Western contexts use.

Neo-prophetic pastors saw their role as spiritual practitioners, who's spiritual 'power' determined their ability to treat mental illness, their role in mental healthcare is directly linked to their spiritual capacities (Kpobi and Swartz, 2019) (QL4). Clergy in this study use prayer and exorcism to diagnose and treat mental illness among congregants and may use other spiritual aids such as fasting and holy water. These clergy were not against biomedical treatment and often encouraged it however clergy held unrealistic expectations that biomedical care should cure mental illness completely (Kpobi and Swartz, 2019) (QL4). Even though

clergy in this study are willing to refer congregants for formal mental healthcare the criterion is based on spiritual diagnosis, which can be unclear and unsystematic.

Asamoah et al. (2014) (QL1) saw that clergy viewed their roles as providing spiritual treatment (exorcism, spiritual counselling and prayer) for illnesses deemed spiritually influenced, providing psychosocial support and providing health awareness to congregants. However, clergy in this study cite inadequate resources, stigma in the church and mistrust between the church and formal health structures as barriers to treatment and their role in mental healthcare. The evidence suggests that clergy that mainly adopted Supernatural conceptualisation of mental illness view their role as providing specialised spiritual diagnosis and treatment. However, the evidence is not clear on the measures these clergy use to specify their roles and delineate the extent of the roles. This lack of clarity may be impacted by the nature of Supernatural beliefs about mental illness which are often culturally and religiously laden and involve criteria that are context specific and difficult to interpret from the point-of-view of secular understandings of mental illness (Leavey, 2010) (QL6).

This theme explored the study's objective to identify preferred intervention/referral pathways. The evidence above suggests that clergy's conceptualisation of mental illness, their perceived role in their congregant's mental health care, socio-cultural context and access to resources and mental health services share symbiotic relationships that result in various treatment and referral pathways. The treatment options clergy engage in are a culmination of these factors and highlight the broader impact of clergy's immediate and overarching environment on their representation and treatment of mental illness. Clergy's conceptualisation of mental illness influence how they perceive their roles in mental health treatment. Clergy that conceptualise mental illness according to the Biopsychosocial Model are more ready to refer

members to mental health practitioners while clergy that hold Supernatural conceptualisation use spiritual/religious treatments.

4.3.7. Influence of the socio-cultural context

Table. 11

Socio-cultural context	Source
	1. Aramouny, C., Kerbage1, H., Richa, N., Rouhana, P., Richa1, S. (2019); 2. Asamoah, M. K. Osafo, J and Agyapong, I. (2014); 3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014); 4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017); 5. Karadzhova, D., & White, R. (2016) 6. Kpobi, L. N. A., & Swartz., L., 7. Leavey, G. (2010); 8. Magliano, L. Citarelli, G., & Affuso, G. (2021); 9. Murambidzi, I. (2016); 10. Stanford, M. & Philpott, D. (2015); 11. Yamada, A.-M. Lee, K. K. Kim, M. A. Moine, M. and Oh, H. (2019)

The third theme that was identified during the review was the impact of clergy's socio-cultural context on their engagement with mental illness. As already alluded to, Western and non-Western societies experience and engage mental health differently and this is reflected in how clergy frame their overall engagement with mental health knowledge and treatment. Furnham and Hamid (2014) found in their review of literature investigating mental health literacy in non-Western countries that mental health literacy increases among its population the

greater the development of a country. Socio-economic factors have also been seen to be associated with mental health literacy, people from urbanised communities show greater knowledge of mental health the people from rural surroundings (Furnham & Hamid, 2014). Western societies have had the privilege of advanced development and scientific superiority due to colonial rule, which has allowed for increase of mental health literacy in their populations over time (Holman, 2015). Non-Western societies in comparison have not had this privilege broadly and due to the historically Eurocentric focus of psychiatry and psychology, the manners in which these societies have understood mental illness have been shunned (Segalo & Cakata, 2017). Mental health and its treatment across cultural contexts is telling of how specific societies frame mental illness and of the conditions which support these understandings.

Theme 1 (*Influence of Biopsychosocial Conceptualisation of Mental illness and Supernatural Influences on mental illness*) of the current study alluded to the association between the representation clergy hold about mental illness and its tenets to their broader socio-cultural surroundings. The current study observed that across the reviewed studies, conceptualisations of mental illness tended to vary according to the socio-cultural background in which clergy participants exist within. It was mainly clergy from Western contexts mainly used the Biopsychosocial Models of mental illness while clergy from non-Western contexts referenced spiritual models. It has been stated that Western countries have higher mental health literacy than non-Western countries (Altweck, Marshall, Ferenczi, & Lefringhausen, 2015). Contemporary psychology and psychiatry themselves emerge from Western contexts and have developed in tandem with Westernisation and Eurocentric modernisation, implying that to various degrees modern psychiatric models of mental illness are not ‘organic’ to non-Western societies, resulting in a form of disconnection (Gopalkrishnan, 2018). ‘Socio-cultural’ context also includes notions related to structural experiences stemming from surrounding socio-

economic conditions and geopolitical underpinnings. The provision of mental health services between Western and non-Western countries is also an influential factor in socio-cultural contexts, economic and technological differences have tenets on help-seeking behaviour within communities (Kopinak, 2015). The tone of difference between Western and non-Western societies and their engagement with mental health sets the platform for how clergy across varying contexts conceptualise and treat mental illness.

Western contexts are marked by trails of economic and industrial advancement that stem from colonial rule, Western societies also are characterised by Eurocentric ideologies (Yazid, Hamid, Folmer, & Beaumont, 2014). Populations in non-Western contexts tend to be more enmeshed with indigenous/ethnic cultures and base their mode of living on principles and ideas that are specific to their socio-cultural environment (Lewis, 2001). Under these distinct socio-cultural contexts, knowledge and understandings of mental health will be experienced variably across cultures and communities. Therefore, there exists an epistemological misalignment where Western psychiatric knowledge has been favoured and assumed across societies without consideration of varying cultural frameworks for mental illness (Gopalkrishnan, 2018; Leavey, 2010). Studies such as those reviewed that investigated clergy's representation of mental illness may be limited by their assumption of referencing Westernised standards and ways of understanding mental illness without in-depth engagement with their cultural contexts. The reviewed studies highlight that there is a need to engage clergy and their role in mental illness with particular attention to their socio-cultural contexts.

The findings and remarks from the reviewed articles highlight the dynamics around clergy's mental health representations and their socio-cultural context. Hankerson et al. (2013) (QL2) noted that African American clergy participants conceptualised mental illness with reference to the socio-economic conditions black African Americans exist in. Another study

by Jang et al. (2016) (QL3) observed that Korean pastors noticed a gap in mental health services attuned to Korean immigrant socio-cultural realities, Korean clergy occupy roles as community leaders and resonate with their constituents through shared beliefs that are translated in their treatment of mental health. Kpobi and Swartz (2018) (QL4) noticed the influence of indigenous supernatural beliefs and worldview on Clergy, this is apparent in the similarity between clergy's Christian beliefs and their surrounding cultural context. Yamada et al. (2018) (Q3) expresses that the variations between clergy participants' conceptualisation and treatment of mental illness lie in various '*cultural scripts*' provided to clergy, they found that even theology can be influenced by socio-cultural factors. Leavey (2010) (QL6) saw these differences among their clergy participants, black African clergy appeared to have a supernatural framework for mental illness while 'mainstream' clergy from Western Eurocentric denominations adopted biopsychosocial frameworks of mental health, this variance highlights the influence contextual factors hold. It appears that when discussing clergy's representation and treatment pathways of mental illness, studies must pay attention to those clergy's socio-cultural context and this will make sense of how beliefs, perceptions and treatment mutually interact with socio-cultural factors unique to specific communities.

What is clear from the evidence is the mental health gap that exists between Western and non-Western societies, and how this gap exists due to differences in material, educational, socio-political and socio-cultural factors. Within non-Western societies there appears to be a mismatch between formal mental health services and church communities from an epistemic and material standpoint, this is characterised by the mistrust and lack of collaboration between the two sects (Kpobi and Swartz, 2018; Asamoah et al., 2014; Murambidzi, 2016; Leavey, Loewenthal, & King, 2017). The lack of research in South Africa investigating clergy's perceptions of mental illness re-emphasises that point made above, a lack of collaboration will continue the chasm between formal mental health services and communities, which may rely

on churches for mental healthcare. The present study can assist in bridging the knowledge gap between mental health care and Christian communities by stating the observed dynamics and mechanisms that surround clergy's representation and treatment of mental illness. Bridging this gap provides future researchers with information that creates a starting point for engagement with Christian communities and fosters awareness of the role of socio-cultural factors on engagement with mental illness. The theme described above sheds insight by providing knowledge about the overarching factors that are influential on the perceptions clergy hold about mental illness and their treatment options.

4.3.8. Reviewed Studies Recommendations

Table. 12

Reviewed Studies Recommendations	Source
Collaborations	1. Aramouny, C., Kerbage1, H., Richa, N., Rouhana, P., Richa1, S. (2019); 2. Asamoah, M. K. Osafo, J and Agyapong, I. (2014); 3. Hankerson, S. H., Watson, K. T., Luckachko, A., Fullilove, M. T., & Weissman, M. (2014); 4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017); 6. Kpobi, L. N. A., & Swartz., L., (2018); 9. Murambidzi, I. (2016); 10. Stanford, M. & Philpott, D. (2015);
Improving clergy mental health knowledge	4. Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017); 6. Kpobi, L. N. A., & Swartz., L., (2018); 9. Murambidzi, I. (2016)

The final theme identified across the reviewed studies focuses on the study recommendations provided from the authors. The recommendations from the studies have similar aims and appear to focus on two factors, 1) Collaborations, and 2) Improving clergy mental health knowledge. The evidence from the reviewed studies highlights those authors recognise the importance of clergy and formal mental health collaborations which can be helpful for mental health service delivery, especially in under-resourced communities. Authors across the studies also highlight a general need for research and mental health awareness programmes directed towards assisting clergy gain further knowledge on mental health and treatment.

4.3.8.1. Collaborations

The evidence across the reviewed studies suggests that authors recognise that the lack of trust and engagement between Christian clergy and mental health practitioners is premised on a lack of understanding between the two groups. The following studies: CSD1, QL1, QL4 and QL6 propose that future research and mental health awareness training need to open spaces for clergy and mental health practitioners to listen and be open towards each other about their respective beliefs and approaches to treatment. QL1 and QL4 propose that psychoeducation should be used as a means to engage clergy and mental health practitioners. Asamoah et al. (2014) (QL1) states that clergy and mental health practitioner trainings need to be developed to bridge the lack of trust between these two groups. Kpobi and Swartz (2018) (QL4) see that collaboration hinges upon clergy receiving psychoeducation and mental health practitioners appreciating religious belief systems. The studies mentioned above highlight the need for conversations as vehicles to promote collaboration, this requires that platform be created through research, intervention initiatives and policy development. Other authors (QL2, QL3, and QL7) view collaboration as a means to mitigate the impact of socio-economic inequities that exist in underprivileged communities, clergy are viewed as useful partners for mental

health practitioners when engaging community mental health care. Hankerson et al. (2014) (QL2) recommend collaborative interventions between clergy and mental health practitioners as they can bridge the impacts of socio-economic impactors in black minority groups. Murambidzi (2016) (QL7) recommend collaborations as they are a means to instigate task-sharing and provide accessible mental health care for church members and their surrounding communities. The abovementioned studies also assert that collaboration is a means to foster task-shifting within communities and engage traditional healers and CHW, this collaboration can also foster referrals between clergy and mental health practitioners. These authors are aware of the chasm between clergy and mental health practitioners, authors propose meaningful collaborations where belief systems and cultural perspectives are engaged with intentionally to build common understanding.

4.3.8.2. Improving clergy mental health knowledge

Evidence from the studies also highlight authors recommending educative measures for clergy to better their knowledge of mental illness. QL3, QL4 and QL7 recommend that training and outreach programmes can assist further clergy's mental health knowledge. Jang et al. (2017) (QL3) recommend that education and training needs to be provided for clergy to foster their skills in mental health identification and treatment. Murambidzi (2016) (QL7) recommend policy implementations which encourage public awareness measures that promote mental health awareness among clergy and church members. Other studies make mention of psychoeducation as possible aims for future interventions and research. Kpobi and Swartz (2018) asserts that psychoeducation for clergy paired with mental health care engagement with church leaders are recommended avenues. There is a common recognition that mental health collaborations can contribute to increasing clergy's mental health knowledge and assist them pick-up skills to intervene with mental illness in their church and community. Recommendations for collaborations and engaging clergy's mental health education appear to

address historically troubling dynamics between Christianity and formal mental health which were identified in the literature chapter such as clashes between mental health conceptualisation and mistrust.

To conclude the above chapter, this study gathered eligible literature within the scope of investigating clergy's perceptions of mental illness and their remedial pathways. Four themes were identified which appeared to capture significant patterns across the studies, these being: 1) Clergy's conceptualisation of mental illness, 2) Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways) 3) Influence of the socio-cultural context, 4) Reviewed Study's Recommendations. The findings suggest that clergy conceptualisation of mental illness mainly differed between Biopsychosocial Models of mental illness and spiritual beliefs of mental illness, however it was clear that the conceptualisations of mental illness differ on socio-cultural context and denominational differences, which have bearing on the type of representation clergy hold about mental illness. Clergy's role in mental healthcare was indicated by their conceptualisation of mental illness, as indicated by previous studies, and the treatment and/or referral pathways were mediated by their beliefs and access to formal healthcare. The findings highlighted the broad theme around socio-cultural factors and their impact in shaping and contextualising the perceptions and treatment methods clergy engage in, this theme highlighted the differences between Western and non-Western clergy and the role their broader society has on their approach towards mental illness. The Reviewed Study's Recommendations from the articles had common tenets as there calls to promote mental health collaborations between clergy and mental health practitioners, and improve the mental health knowledge of clergy, these would help foster better engagement between clergy and formal mental health services. The information provided by the current study can help provide better context in understanding clergy's engagement with mental health related issues and assist researchers and mental health

practitioners reflect on the necessary level of engagement needed when collaborating with Christian churches and their leaders. There is a current trend in mental illness to involve traditional/religious healers and CHW's in service delivery as an attempt at task-shifting, the study sheds light on the dynamics that can occur when Christian church leaders are being involved. The socio-economic impact that the COVID-19 pandemic and other socio-political events in South Africa have adversely impacted the quality of life of multitudes of people, which may produce a crisis in mental health on top of an already existing mental health treatment gap (Nguse & Wassenaar, 2021). De Kock and Pillay (2019) recognise that in underprivileged communities such as rural areas in South Africa are need of inventive and research led ways of task shifting is integral to providing mental health services. However, the paucity of studies investigating church leader's engagement with mental health in South Africa highlights a research gap that can limit future endeavours between the Christian church, clergy and mental health practitioners. Soon, engaging church leaders may need to become a necessary part of mental health treatment in South Africa and this study echoes the need for further research in this topic.

Chapter 5: Conclusion, Limitations and Recommendations

5.1 Conclusion

The present study mapped and synthesised evidence from studies that investigated church leader's representation of how Christian beliefs inform mental illness identification and remediation (referral pathways) in vulnerable church members. In accomplishing the study objectives this research:

- Explored existing evidence of church leaders' perceptions of mental illness and their role in remediation and treatment
- Explored and attempted to understand how Christian beliefs inform perceptions of mental illness
- Explored clergy's preferred intervention/referral pathways (i.e., religious and/or mental health professionals)

A total of eleven studies were identified by meeting the requirements of the inclusion criteria of the search. Many of the studies shared similar characteristics (i.e., aims/objectives, methodologies and outcomes). Thematic analysis of the evidence produced four themes that were identified from the studies:

1) Clergy's Conceptualisation of Mental Illness. This first theme identified in the study satisfies the second objective outlined above. Clergy's conceptualisation of mental illness could be sub-categorised as the Influence of the Biopsychosocial Conceptualisation of mental illness and Supernatural Influences of mental illness. The Biopsychosocial framework is understood as a Western and modern psychiatric model of mental illness that stems from scientific enquiry. Clergy adopt this model are more likely to have been in contact with or exist in Westernised societies. The studies suggest that where clergy purport adopted

Biopsychosocial understandings of mental illness there is not much endorsement of Supernatural influences on mental illness. In a modernised Western setting supernatural beliefs do not appear to have much relevance. Supernatural Models of mental illness were adopted by clergy that uphold spiritually inclined beliefs about mental illness, particularly in non-Western cultures. Supernatural influences of mental illness are attributed to either external unbenign spiritual entities or internal moral failings, these attributions appear to perpetuate stigmatising beliefs.

2) Role of Clergy in remediation/intervention regarding suspected cases of mental health issues (referral pathways). The evidence from the study highlights that clergy's perceptions of their role and their remediation pathways in mental healthcare is largely premised by their conceptualisation of mental illness. Regardless of the conceptualisation of mental illness, clergy were not opposed to referring vulnerable church members to relevant mental health practitioners, this can be mediated by Christian values and access to formal healthcare. The studies suggest that clergy perceive their role specialised to providing spiritual and emotional care, however the extent to which this role is emphasised is variable according to the conceptualisation of mental illness. Clergy's role in mental illness is not only decided by their beliefs but their socio-cultural context and access to mental health services shape their engagement. Clergy's acknowledgement and use of referral options suggest that they are aware of the available formal mental health services and engage them in varying degrees. However, clergy and church leaders from previously disadvantaged communities and non-Western contexts may rely on their own laurels and treatment due to a lack of formal mental health services available.

3) Influence of the socio-cultural context. The current study found that across the reviewed studies, historic socio-cultural factors have bearing on the types of knowledge that

clergy have about mental health. The main socio-cultural differences identified in the study were according to Western and non-Western contexts and how they provide an epistemic framework for clergy to base their beliefs and knowledge of mental illness on. Clergy from Western backgrounds may hold more scientifically acceptable models of mental illness unlike clergy from non-Western backgrounds who most likely will base their knowledge of mental illness on culturally and religiously based beliefs. Church leaders and clergy do not represent Christianity isolated from socio-cultural influences. However, clergy are participants in the promulgation of widely held beliefs about mental illness. The abundance of qualitative studies may suggest that authors are aware of the need to understand clergy's perceptions and treatment of mental illness in a contextualised and nuanced manner. The current study finds that the representation of clergy's knowledge about mental illness may appear to 'classed' due to the socio-cultural differences between clergy from Western and non-Western societies. This socio-cultural difference appears to have a role in the chasm between clergy and formal mental health services. Collaborations between clergy and mental health practitioners have historically been characterised with mistrust and a lack of understanding (Heseltine-Carp, & Hoskins, 2020). This disparity can become even clearer when clergy from non-Western contexts who hold religious/cultural beliefs about mental illness engage with formal health services which are grounded on Western scientific models of mental illness, these epistemic differences position clergy and mental health practitioners on polarising ends. This epistemic difference is seen in the lack of training for both clergy and mental health practitioners on the knowledges, practices and beliefs of either group (Leavey, 2008; McRay et al., 2001; Wood et al., 2011; Foskett et al., 2004). Efforts need to be made to bridge the gap between clergy and mental health practitioners and promote collaborations, this may happen when a mutual appreciation for each group's epistemic positions and socio-cultural contexts which shape knowledge and practices around mental illness.

4) Reviewed Study's Recommendations. The final theme identified in the study was around the recommendations offered by the identified articles for this scoping review. The recommendations for the studies were focused on increasing collaborations between clergy and mental health practitioners and increasing the mental health knowledge of clergy. The need for collaborations between clergy and mental health practitioners was mainly based on the apparent discordance between these groups. Authors recommended that collaborations need to emphasise conversations and meaningful engagement that will help both clergy and mental health practitioners understand each other's mental health perspectives. Collaborations are seen as useful means to bridge the mental health gap in previously disadvantaged communities that cannot access formal health services or who require more culturally/spiritually relevant modes of care. Certain authors see collaborations as means to foster task-shifting and engaging informal mental health services for vulnerable church members. Authors also recommended increasing the mental health knowledge of clergy mainly through psychoeducation and training. The authors recognise a skills and knowledge gap among clergy, particularly for clergy that may not be accustomed or completely accepting of Western models of mental illness. These recommendations highlight the need for constructive engagements between religious groups and formal mental health services. The epistemic gap between these groups should not be used as an excuse for continued discordance but should be viewed as an opportunity to bridge knowledge gaps and create relevant mental health service systems that can be beneficial for vulnerable persons that are represented by clergy and mental health practitioners.

The current study investigated clergy's perceptions of mental illness and their remedial pathways. However, the scoping review search yielded a few studies in the African context but there were none from the South African context. This shortage of studies in the South African context highlights a lack of research interest in this topic and may also be indicative of the

overall resource shortages for psychological research. There is a mental health crisis in South Africa which is reinforced by the mental health treatment gap underpinned by inadequate mental health resources (especially in underprivileged areas), engaging community health workers such as clergy can be an important outlet in task-shifting (Sibeko et al., 2018). The current study mainly identified studies of qualitative design and few which were quantitative or mixed method design, this implies a lack of studies in this topic that are interested in generalisable and empirical evidence. This may imply that interests in this topic are around gaining understandings and meanings about clergy's perceptions and treatment of mental illness.

5.2. Limitations

The current study sampled (n=11) studies that were selected using a prescribed inclusion and exclusion criteria made for the purposes of this study. The evidence received from the articles does not lend itself to generalisability as the sample size is not representative of the clergy population. More so, the clergy population that is representative of this study is narrow particularly regarding factors such as ethnicity, denomination, nationality and language. The inclusion/exclusion criteria used for this study may limit the access to research relevant for this topic. The study included clergy from Christian sects that emerge from traditional Judeo-Christian belief systems, however, this can be limiting to the study as Christianity is experienced and practiced differently across cultures and communities (Beyers, 2017). Mental illness in this study was constrained to investigating clergy's perceptions of depression, anxiety and general mental illness, this may exclude other evidence of clergy's perceptions about other mental illnesses, this limits the breadth at which this topic can be investigated. The inclusion criteria for this current study required only studies that were written in English to be included. This can limit other cultural narratives that are accessible from

languages other than English, studies of larger scale that investigate this topic may find this useful to understand the complex between spiritual beliefs and mental health knowledge.

5.3. Recommendations

The evidence from the study highlighted the importance of socio-cultural factors in how clergy conceptualise and treat mental illness. Future studies in this topic can benefit from engaging not only clergy's spiritual/religious beliefs but they can investigate culture as an analytic tool to better understand how clergy's beliefs impact their treatment and referral options. The current study noticed the lack of South African studies which investigate clergy's representation and treatment of mental illness. There is a mental health treatment gap in South Africa that deems many citizens incapable of accessing assistance in due time, utilizing clergy and church structures as points for community mental healthcare can be an impactful intervention. However, the lack of research on clergy and their engagement with mental illness limits this potentially useful option. Clergy have already been identified as mental health gatekeepers by virtue of their role in community healthcare, further research can assist bridge the gap of collaboration with mental health practitioners.

Evidence from the study highlighted that many studies recommended clergy and mental health practitioner collaborations. This study further recommends that future studies and interventions which involve the church, clergy and mental health practitioners should focus on implementing interventions and trainings aimed at inspiring dialogue about mental health, belief systems and treatment. Approaches with this aim can help both clergy and mental health practitioners gain common understanding on the other's engagement with mental illness. Constructive collaborations between clergy and mental health practitioners have the needed advantage of benefitting vulnerable church and community members. The development of church-based interventions offers mental healthcare a new juncture in which it can engage those who need

these services and judging by the state of mental healthcare in South Africa, a new treatment pathway should be offered attention due to the great need for mental health services.

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