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Pastoral Care and Mental Health in Post-Pandemic South Africa: A Narrative Review Exploring New Ways to Serve Those in Our Care

Janice K. Moodley [1,*] and Rabson Hove [2]

[1] Department of Psychology, University of South Africa, City of Tshwane 0002, South Africa
[2] Practical Theology, Seth Mokitimi Methodist Seminary, Pietermaritzburg 3201, South Africa
* Correspondence: moodljk@unisa.ac.za

Abstract: COVID-19 has had severe consequences for congregants worldwide. During the period of lockdown regulations, congregants were isolated from pastoral care when such care was most needed. Social distancing, wearing masks, and other regulations changed how we worshiped, fellowshipped, discipled, counselled, comforted, and loved those in our care. The role of pastoral care as a pillar of mental well-being became overwhelmingly evident as the dying, the grieving, the physically and mentally ill, the abused, the starving, the destitute, and the vulnerable were isolated and alienated. The pandemic has had untold consequences on congregant mental health, especially in resource-poor contexts in South Africa, where adequate psychological services cannot cope with needs. This article uses the narrative approach to explore the possible role pastoral care can play in addressing the exacerbation of mental health issues post-pandemic in South Africa. The state of psychological services in South Africa is explored in order to contextualise the need for innovative ideas to address the complexity of mental health issues in South Africa. Recommendations are made for how pastoral care may be utilised to alleviate the mental health crisis that has emerged following the pandemic at an individual and community level. Hopefully, this article will foster critical dialogue between theological and psychological scholarship for the purposes of alleviating the complex mental health issues that persist in South Africa and have been exacerbated by the pandemic.

Keywords: COVID-19; mental health; pandemic; pastoral care; post-pandemic; psychology; South Africa

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1. Introduction

Pastoral care is an essential pillar of integrated well-being for Christian communities worldwide. The role and need for pastoral care amplified as the pandemic ravaged congregants' physical, spiritual, and psychosocial well-being (Ferrell et al. 2020). The COVID-19 pandemic created a paradox in that people were isolated from their loved ones and basic pastoral care at a time when this social interaction was most needed. The dying, the grieving, the physically and mentally ill, the abused, the starving, the destitute, and the vulnerable were isolated and alienated as lockdown, social distancing, the wearing of masks and other regulations changed the way we worshiped, fellowshipped, discipled, counselled, comforted and loved those in our care.

This abrupt disruption of normal routine in the face of an unknown threat escalated psychological illnesses such as anxiety and depression in specific population segments during the pandemic (Gloster et al. 2020; Penninx et al. 2022). This is consistent with scholarship from previous natural disasters, pandemics, and other collective traumas, which indicated increased mental health issues (Manderscheid et al. 2010; Mechanic 1999) following these traumas (Esterwood and Saeed 2020; Fong and Iarocci 2020). It, therefore, stands to reason that the pandemic would have exacerbated mental health issues in South Africa, particularly within the context of historical collective trauma (Adonis 2016) due to colonialist and apartheid rule, which will be expanded upon in the sections to follow.

However, the current ailing mental health infrastructure in South Africa is under-resourced, necessitating the need to explore the role of pastoral care in assisting in alleviating the mental health crisis in South Africa.

Traditionally, psychology and pastoral care within the church (Magezi 2022) have been separate factions. However, the lack of resources to address pandemic-related mental health concerns provides an avenue for conversation. Exploring the role of pastoral care in promoting mental health well-being may be a critical bridge in reaching the masses of South Africans that already experience historical collective trauma due to other historical atrocities, such as medical racism following colonialist and apartheid rule (Moodley and Oppong 2023). This article explores the historical mental health context within South Africa to highlight gaps within the psychological profession, in order to address the mental health crisis post-pandemic adequately. The literature on pastoral care and mental health within the context of Covid-19 is explored to understand the need for workable solutions. Recommendations are made for how pastoral care can assist in alleviating the mental health crisis post-pandemic. The article then concludes with a discussion of future implications for research and recommendations for practical strategies.

This article is written using a narrative approach (Baumeister and Leary 1997; Ferrari 2015) and self-reflexively (Poortaghi et al. 2019), by two academics brought together by our faith and our experience of the pandemic, mental health issues, and pastoral care in South Africa. The first author is a South African psychological practitioner, academic, and a third-generation born Christian from Pentecostal origins with Charismatic underpinnings. The second author is a Reverend and theological scholar from the Evangelical Lutheran Church (Zimbabwean Diaspora) with two congregations in Kempton Park and Randburg, Gauteng, South Africa. Together we used a transformative theoretical lens (Al Riyami 2015), as we combined a narrative review of appropriate literature with our experiential knowledge of congregants suffering from mental health issues following the pandemic. These congregants may not have access to psychological services because of socio-economic and structural issues that prevent the vast majority of South Africans from receiving appropriate mental health care. With the need to move on from the pandemic, we have found that many churches may have forgotten that the impact (positive and negative) of the pandemic remains in various forms. The article is written as a proactive conversation aimed at discussing the possibilities that pastoral care presents in assisting in alleviating mental health issues from an individual and community perspective.

2. Pastoral Care, Mental Health Well-Being, and the Pandemic

Pastoral care has been historically defined as intentionally enacting and embodying a theology of physical presence. For example, Byrne and Nuzum (2020) explain pastoral care as a "relational endeavour" "enhanced through the appropriate use of touch, ritual, and gesture alongside the use of silent reflection and deep listening" (p. 208). Penninx et al. (2022, p. 381) define pastoral care as a "ministry of presence" as quoted in Patton (2005), with presence being understood as a physical presence. As an embodied act of God's love (McClure 2012), pastoral care describes a very special process of caring: caring for human life because it is created by God, belongs to God, and is saved by God in Christ (Louw 2015). It is the general supportive care given to the community of faith members by the laity and the clergy in times of crisis (Patton 2005; Doehring 2014). Hove (2022) argues that pastoral presence is helpful in giving comfort through accompaniment, as such presence would represent the presence of the caring other, the community of faith, and the loving God. It is an act of love typically rendered during illness, end-of-life proceedings, suffering, and trauma (Byrne and Nuzum 2020), but these became impossible acts of love during the pandemic. Magezi (2022) explains the impact of the pandemic restrictions as affecting "the very heart and soul of what it means to be humane and relate to others" (p. 5), as the church was forced to care from a distance.

Online platforms became invaluable in reaching congregants. Technology provided a means to maintain a connection between the church and its congregants who were discon-

nected due to lockdown restrictions (Byrne and Nuzum 2020). The use of video calling, phone calls, Zoom, and WhatsApp communication helped to maintain easy, affordable, and safe accessibility, as it did not involve risk to people's lives during the period of restrictions of people's movement because of the COVID-19 pandemic (Afolaranmi 2020). In many cases, congregant numbers grew because more congregants could connect from the comfort of their homes. However, the online space also emerged as a socioeconomic divider, as many church leaders and congregants lacked the technical skills and financial resources to buy smartphones and computers and have access to Wi-Fi and data in order to engage with congregants online (Ferreira 2016; Magezi 2022; Osei-Tutu et al. 2021; Hove 2022). This is particularly significant in areas with connectivity issues, lack of digital resources, and financial constraints to accessing live streaming. Additionally, the online space could not replace the warmth of a Christian embrace and the love of God during times of absolute desolation or the administering and receiving of Holy Communion (Magezi 2022). In some instances, the lockdown restrictions led to spiritual decline (Osei-Tutu et al. 2021), which no doubt led to mental health concerns, given that religion and spirituality have been considered a buffer against an array of mental illnesses, such as depression, suicide, dementia, substance abuse, and stress-related disorders (Bulling et al. 2013; Lloyd and Kotera 2022).

As with any other threats to human life, the issues of COVID-19 and mental health care are critical issues of pastoral care that cannot be avoided. The various challenges posed by the pandemic have exacerbated mental health problems. It is essential for pastoral care to respond, since there is a need for pastoral care and practical theology to attend to contextual issues (Louw 1997). Louw argues that failure to contextualize pastoral care results in the church becoming divorced and "estranged from the real-life issues" (Louw 1997, p. 402). Mental health issues caused by the pandemic need contextual pastoral care responses because they are existential matters that cannot be ignored.

The advent of COVID-19 brought many challenges which caused mental health problems. For example, caring for sick family members is a deeply entrenched African cultural tradition. COVID-19 restrictions prevented this simple act of love from being enacted and received, leaving many congregants in deep despair. Many loved ones died alone, leaving a seemingly inconsolable hurt in those left behind, because the pandemic disrupted burial and mourning rituals. Lockdown measures and other specific lockdown-level restrictions meant that family members could not visit their loved ones in the hospital or even say goodbye to them as they passed on.

Among other challenges that continue to haunt congregants was the failure to attend funerals and bury their loved ones with dignity during the pandemic. The lockdown regulations prevented people from crossing provinces, cities, and districts to attend the funerals of their friends, family members, and relatives. In some instances, less than 30 to 50 members could attend the funeral but were not allowed to bathe their loved ones, or even view their remains in some instances. In normal situations, the death of a loved one is a deeply psychologically distressing experience, with the bereaved experiencing appropriate symptoms of depression and anxiety, while others may experience protracted maladaptive reactions to loss (Chen 2022). The inability of congregants to care for, support, and bury their loved ones may lead to intense psychological distress due to guilt, anger, resentment (Chen 2022), derealisation, and constant rumination (Testoni et al. 2021), leading to the risk of complicated grief.

Within various South African church denominations, culture is inextricably intertwined with religion. This is enacted in the act of burial. In Africa, and South Africa in particular, a normal "funeral would be characterized with gathering of family and friends and night vigils and big send-off to the loved one" (Humbe 2022, p. 5). The bereaved are consoled, surrounded by the family, community, and the church. The pastor and the congregation of the deceased's family would conduct pre-burial, burial, and post-burial services. This form of pastoral care and accompaniment helps the bereaved to be comforted, healed, and obtain closure. In some dominations in South Africa, the presence of family

members has cultural implications. They become connected with the spirit of the departed, including the long-departed ancestors, during the burial of the loved one. This sacred custom came to an abrupt halt during pandemic protocols as a way of reducing the spread of the pandemic (Humbe 2022). The numbers permitted at funerals were too small to accommodate the family and extended family, members of the local community, and the church. Various congregants, however, experienced lasting trauma for displeasing and disrespecting their loved ones (Baloyi 2014) because they could not bury them. They could not attend funerals due to the limited numbers required, while others were not allowed to travel across the provinces. The mental anguish experienced by these congregants has exceeding long-term consequences because of the cultural belief that if you do not attend a funeral or participate in cultural rituals, you will be cursed or haunted by the departed (Mbiti 1991; Baloyi 2014). Such mental anguish could potentially manifest as mental illness. The unique role of pastoral care in providing relief for these anguished congregants should not be undervalued, given the intimate role that the church plays in burials. However, pastoral care may be ill-equipped to deal with the psychological consequences of such trauma, necessitating the need for upskilling the church in merging biblical teachings with psychological responses to grief and loss.

However, historically, mental illness has been stigmatised and spiritually reduced in some denominations as an act of sin, possession, a lack of faith (Lloyd 2023), or a generational curse (Lloyd and Kotera 2022) that can be resolved through prayer. At the other extreme, some denominations conceptualise mental illness as a medical or psychological illness outside the authority of the church (Lloyd 2023). In the African context, the majority of mental health challenges would be referred to traditional healers, who would use rituals and special herbs to treat the patient (Humbe 2022). Debunking myths about mental illness is essential, as they are associated with poor health-seeking behaviours and treatment outcomes (Egbe et al. 2014). There is a need to approach mental health issues holistically. This includes pastoral care through prayer and counseling, as well as seeking medical attention where need be.

3. The State of Mental Health Care in South Africa

The state of mental health within the South African population is primarily influenced by the transgenerational transmission of trauma (Volker 1996 in Adonis 2016) caused by colonialist and apartheid regimes of racial oppression. According to Adonis (2016, p. 1), "colonialism and Apartheid had severely damaged the social fabric of South African society", the trauma of which has left profound psychological impacts on black South Africans. It, therefore, stands to reason that black communities would be the most affected by compound mental health problems. Additionally, legacies of socioeconomic inequalities (combined with existing political mismanagement of resources) perpetuate health and mental healthcare inequalities such as access to adequate healthcare. For example, research suggests that South Africans prefer to seek psychological services from health professionals from comparable racial and cultural backgrounds. However, disparities within the psychological profession dictate that most psychologists are white, with only 17% of practicing psychologists being black (Padmanabhanunni et al. 2022).

South Africa has a high prevalence rate of mental health illnesses. South Africans suffer higher rates of mental health disorders, such as depression, anxiety, and substance abuse, than other African countries (Padmanabhanunni et al. 2022). Just as the need for a peaceful transition from apartheid to democracy glossed over the atrocities millions of South Africans suffered at the hands of transgressors, so too have the mental health consequences of the pandemic being side-lined as the push to pre-pandemic normality dominated. However, even pre-pandemic, 60% of South Africans were estimated to have Post Traumatic Stress Disorder, with one in six South Africans plagued with depression or substance abuse (Nguse and Wassenaar 2021). One in three South Africans is estimated to have developed a severe mental health illness (Kim 2020). The pandemic perpetuated gaps in access to quality mental health healthcare within a fragile health system. Only

27% of individuals with severe mental illnesses are estimated to receive treatment because of understaffed (Nguse and Wassenaar 2021) and under-resourced, decentralised mental health services (Posel et al. 2021).

South Africa is a country that is undeniably psychologically affected by gross historical atrocities. The COVID-19 pandemic has compounded the psychological impact that cannot be solely addressed by the country's ailing mental health care infrastructure. Intersectoral collaboration is needed to assist in alleviating the mental health crisis evident within the South African context. The mental health profession has made a longstanding realisation that religion or spirituality may play a significant role in alleviating mental health conditions such as depression (Breuninger et al. 2014). Subsequently, it is recognized that an individual's psychological well-being may benefit from engaging with faith-based leaders. Therefore, a radical collaboration between mental health care professionals and pastors may assist in alleviating the burden of post-pandemic mental health issues. This may be a prudent approach, given that pastors may have a wider reach and be able to form deeper connections of care than mental health professionals can. Evidently, the highest density of mental health professionals is concentrated in urban areas. It is proposed that pastoral–psychological empirical research and subsequent interventions may address an integral gap in reaching and assisting congregants who may never receive assistance for mental health issues.

South Africa has just 2.5 psychologists per 100,000 population compared to 33.3 psychologists per 100,000 in the United States of America (Padmanabhanunni et al. 2022). Therefore, instead of incorporating religious or faith-based beliefs into psychology, psychology may need to become incorporated into the daily skill set of pastoral care. There would need to be a rethinking regarding how pastors could become formally trained in obtaining counselling skills that the Health Professionals Council of South Africa accredit. However, gatekeeping issues could obstruct exploration of this avenue. In times of crisis, particularly within contexts like South Africa, compounded by historical inequalities caused by colonialist and apartheid racial oppression, gatekeeping should be responsibly re-imagined to serve those most in need. Psychology, as a profession, has been found guilty of compliance with the gross historical injustices enacted within the South African context (Padmanabhanunni et al. 2022) and, therefore, should make innovative strides in addressing mental health issues through multisectoral collaborations.

The COVID-19 pandemic thrust individuals into captivity almost overnight. This social isolation resulted in individuals losing adaptive and maladaptive coping mechanisms for mental well-being. Individuals were abruptly alienated from social support systems and networks, recreational activities, spiritual endeavours, and educational pursuits, while individuals with addictions to alcohol, tobacco, and other illicit addictive behaviours could not find psychological relief during periods of hard lockdown. Sudden and severe lockdown and quarantine measures in South Africa reduced individuals' access to mental health care and other essential health services (Nguse and Wassenaar 2021). Research indicates that South Africans with pre-pandemic mental health problems experienced increased depressive and anxiety symptoms. However, access to mental health decreased as Covid-19 physical health concerns were prioritised (De Man et al. 2022). A study in Ghana found that congregants' fears of contracting COVID-19 led to a decline in visiting healthcare facilities for fear of contracting the virus (Osei-Tutu et al. 2021).

The psychological impact of the pandemic due to socioeconomic stressors and other pandemic-induced traumas is evident but underexplored. For example, between 2.2 million and 2.8 million South Africans lost their jobs during the first four months of the lockdown, causing untold damage to psychosocial well-being (Posel et al. 2021). Social bonds in communities have been established in scholarly literature as a preventative mechanism against violence and crime (Eagle 2015). Fearfulness and social withdrawal have been identified as eroding social accountability mechanisms and the monitoring of violence and crime (Eagle 2015). It is, therefore, not surprising that gender-based violence increased as

anxiety and isolation increased during the pandemic, the exact effects of which remain largely unknown and untold.

The failure to obtain pastoral and other professional support for mental health care issues results in higher rates of suicide, substance use and mental health disorders, domestic violence, and other problems (Bulling et al. 2013). During the COVID-19 epidemic, a few cases of suicide and more cases of domestic violence were reported. Domestic violence refers to "any incident of threatening behaviour, violence (psychological, physical, sexual, financial, emotional), or abuse between adults who are or have been an intimate partner or family member, regardless of gender or sexuality" (Karystianis et al. 2019, p. 21). In some instances, one may argue that such violence might have resulted from mental health challenges due to economic strain. Ndlovu et al. (2022) argued that the impact of COVID-19 led to domestic violence due to unemployment, financial stress, emotional stress, and failure to have sufficient income to put food on the table. The family stayed together at home for long hours without any economic activity or income and without food on the table. Domestic violence increased in South Africa due to lockdowns and long-time isolation at home, insecurity, and lack of necessities (Mahlangu et al. 2022). This traumatises both the couple and the children, who used to go out to work and school.

Even pre-pandemic mental illness contributed to a high disease burden globally. It stands to reason that increases in mental illness associated with environmental stressors, such as anxiety disorders, depression, and alcohol abuse disorders, would be exacerbated by the pandemic (Penninx et al. 2022), especially in under-resourced contexts. Psychological services in South Africa remain understaffed pre- and post-pandemic, necessitating the need to explore alternative resources to assist with promoting mental well-being. Pastoral care offers one such underexplored avenue in the theological and psychological literature. This is concerning, since pastors may regularly encounter congregants' mental health issues, such as depression, in their daily pastoral care duties (Haußmann et al. 2020). Additionally, the access and fellowship that pastoral care facilitates may provide opportunities for promoting mental well-being, particularly in South Africa, where psychological services are scarce. The presence of the pastor and accompaniment from other church members help to bring healing and the opportunity to witness deteriorating situations that may need referrals.

4. Recommendations and Implications for Pastoral Care Post-Pandemic

The pandemic has been devastating for congregants the world over. Yet it also serves as an important juncture where the role of pastoral care can be refined to serve in addressing the mental health needs of populations in need.

There is a dearth of literature on how pastors and their congregants responded to, were affected by, and continue to be affected by the pandemic (Johnston et al. 2022). Scholarly research is, therefore, desperately needed to assist in documenting the effects of the pandemic. Additionally, further research is needed to understand how the pandemic affected vulnerable populations such as children, so that appropriate pastoral–psychological interventions can be implemented. For example, a multicultural systematic review found that pandemics such as COVID-19, SARS, H1N1, and H5N1, which utilised isolation to prevent disease transmission, negatively impacted children's mental health through child anxiety and fear symptoms and post-traumatic stress disorder (Fong and Iarocci 2020). The increase in gender-based violence during the pandemic further highlights the need for marital counselling and pastoral–psychological interventions. Such interventions can assist in creating cultural shifts in how women are perceived and treated within a culture of violence in South Africa.

Research by Lloyd (2023) indicates the overwhelming need for the church to engage openly in dialogue with congregants and psychological and medical professionals regarding mental health. Educational initiatives involving congregants and pastors were recommended to address mental health stigma and find alternative explanations for why the church is not immune to mental illness. The Bible provides various insights into men-

tal health struggles amongst even the bravest and wisest stalwarts. When reading the Book of Ecclesiastes, it is easy to become perplexed by the futility of life when reading of Solomon's poetic melancholy and hopeless despair. David's mental anguish in the Psalms is a reminder that even this spiritual giant experienced obvious mental health concerns. Reflection on the journeys that the great people of faith had to endure may provide relief, hope, and certainty that divine purpose and wisdom are often exposed during periods when war wages exclusively in our minds. Perhaps a useful starting point for destigmatising mental health within the church would be to have open conversations about how the giants of our faith also struggled with their own mental health issues. Many churches have developed apps that have downloadable sermons. It may be beneficial to have such sermons easily categorised in order to alleviate mental health issues, with opportunities for congregants to receive pastoral care and prayer if needed.

Drawing on Lloyd's (2023) suggestion of education initiatives, one of the authors provided pastors with psychoeducation on depression, anxiety, and suicide during the pandemic. This seminar was part of a wider community engagement project at the tertiary institution with which the author is affiliated. The author had presented this seminar previously to congregants in a local community. The positive responses from both these encounters indicated the overwhelming need to demystify and talk about mental health issues in the church. However, such engagements need to be ongoing if they are going to provide sustainable change at a community level. Academic institutions may provide useful connections for theological and psychological scholars to collaborate on pastoral–psychological interventions in South Africa. The philosophy of engaged scholarship (Holland et al. 2010; Zuber-Skerritt et al. 2015) may provide a useful motivation for such collaborations to assist communities, whilst also generating useful empirical evidence.

Lloyd's (2023) research also suggested the need to move from spiritual reductionism to a model of acceptance of people suffering from mental illness, according to the Word of God. Safe spaces and dedicated support groups that merged biblical teachings with care for mental illness provided appropriate intervention for referrals to psychological professionals as needed. Referral between pastoral care and psychological practitioners forms greater collaboration in helping people in distress, struggling with mental health issues. The collaboration creates teamwork in times of psychological distress that cannot be addressed through pastoral care. A referral is a negotiated process to produce helpful results. The client needs to understand that the trusted pastor does not desert him/her into the hands of another professional, who is more of a stranger. Therefore, the pastor needs to discuss the importance of referral with the client so that the client is aware and accepts the additional services. The pastor and the client should have an open and honest agreement.

Additionally, an honest discussion should be held in confidence with the other professional for further help. This enables the other to take over without necessarily starting the process again due to a lack of information about the situation or case, but this should be done with consideration of confidentiality which may jeopardize trust. "The process begins by simply acknowledging that a pastor and mental health provider have different roles" (Singer 2018, p. 34). The process of referral requires increased interpersonal familiarity with colleagues in other mental health professionals and service providers and an understanding of their capacities to help. Churches could build a database of mental health experts that share similar values as their congregants. These experts could act as a database for referrals but could also host various seminars or workshops. These seminars or workshops can provide congregants with practical steps for addressing and living with mental health concerns.

The pandemic facilitated the accelerated adoption of various online technologies that should not be lost as a tool to assist with promoting mental well-being in congregants. Online technologies such as instant messaging and chats, video calls, and emails are being used as counselling tools, but can also be used to reach congregants who remain at home for various reasons. During the pandemic, technology reduced stress levels as people could talk and sometimes see each other's faces during video calls and zoom meetings (Hove

2022). Within South Africa, online services in the evening allow single mothers, the elderly, those with health challenges that keep them immobile, people living in rural areas, and other vulnerable groups to attend cell groups without leaving their homes. The intimate fellowship that cell groups facilitate provides fertile ground from which relevant daily issues, such as mental health concerns, can be discussed and prayed about. It may also allow for identifying at-risk individuals early on, so that appropriate interventions and referrals are made. Post-pandemic pastoral care can merge contact and virtual pastoral care approaches, depending on the context and access to the internet. Those who cannot attend contact services can no longer be denied opportunities for pastoral care, since the virtual space is valuable post-pandemic.

5. Conclusions

This article highlighted the possibility of pastoral care assisting in alleviating the mental health crisis in South Africa that the pandemic has compounded. Historical collective traumas have impacted mental health and well-being in South Africa due to colonialist and apartheid regimes of oppression that have left a legacy for multiple generations. The structural consequences of these oppressive regimes have resulted in those most vulnerable being unable to access mental health care. The pandemic has exacerbated the mental health crisis in South Africa. High levels of crime, gender-based violence, and substance abuse rates are symptoms of mental health issues in the country. Pastoral care may provide urgent assistance in alleviating the country's mental health crisis. Additionally, pastoral–psychological interventions guided by empirical research may be a useful field of study in South Africa to relieve the mental health crisis in South Africa. This requires rethinking psychological and theological training in South Africa so that the needs of those most vulnerable are prioritised over professional gatekeeping.

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