The spiritual factors influencing the health-seeking behaviour amongst the Charismatic Christians in Johannesburg

by

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Topic of research mini-dissertation:

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ABSTRACT

Spiritual factors influencing the health-seeking behaviour amongst the Charismatic Christians in Johannesburg.

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DEGREE: MSW (Healthcare)

INSTITUTION: University of Pretoria

Health-seeking behaviour encompasses the actions, thought processes and decision-making involved in establishing and maintaining a healthy physiological state. As such, various studies have investigated the factors that influence health-seeking behaviour. Such factors included demographic, socio-economic, political, religious and cultural factors. It was however, found that there was a lack of research regarding the specific factors of Charismatic Christians that affect health-seeking behaviour, thus guiding the research question.

The aim of this study was to explore the spiritual factors influencing health-seeking behaviours of the Charismatic Christians in Johannesburg, Gauteng. Through a paradigm of interpretivism, research was conducted using a qualitative approach to explore and describe how the spiritual factors of Charismatic Christians influence health-seeking behaviour. An instrumental case study design was utilised in order to gain insight into the phenomenon of health-seeking behaviour, to create recommendations to facilitate practice and to refine theory to increase health-seeking behaviour among Charismatic Christians. This was done through the use of one-to-one, semi-structured interviews with participants, who were incorporated into the study through voluntary, purposive sampling.

Previous studies found various factors affecting health-seeking behaviour, amongst these were religious factors. Furthermore, there were several studies that explored the health-seeking behaviours of Charismatic Christians, however, this was mainly focused on the mental health domain. To date, little research has been done into the general health-seeking behaviours of Charismatic Christians, which indicated the gap for the research study. The findings of the study both supported and contradicted the specific factors affecting health-seeking behaviour, found in

the national and international studies in the literature review. However, the study agreed with the previous studies, that spiritual factors do affect the health-seeking behaviours of Charismatic Christians in Gauteng.

It can be concluded that participants are not averse to seeking professional healthcare services that are easily accessible, however, unless the symptoms are severe, participants will engage in other methods of self-care prior to seeking healthcare services. Secondly, Charismatic Christianity was found to encourage health-seeking behaviour through teachings of self-control, self-respect, and healing through medicine. Thirdly, it was concluded that in some instances, Charismatic Christianity could deter individuals from health-seeking behaviour as they have a belief in divine healing from God, thus it is not necessary for them to seek formal healthcare services. Lastly, it was concluded that participants have had limited contact with social workers in the healthcare setting, thus limiting their knowledge regarding the role of social work, however, they are willing to engage with social workers in the healthcare settings, if services adhere to ethical standards.

Based on the conclusions of the study, it was recommended that the healthcare team, including social workers, be knowledgeable about the spiritual factors influencing health-seeking behaviour, as well as remain non-judgemental and allow for autonomy of patients. It was further recommended that preventative healthcare be encouraged and promoted within healthcare settings. It was lastly recommended that patients have access to information regarding symptoms and severity, to encourage individuals to seek professional healthcare timeously.

Key concepts:

Spiritual factors
Health-seeking
Behaviour
Charismatic Christianity

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 INTRODUCTION AND CONTEXTUALISATION

Behaviour, is defined as any action or response by an individual, group or community, including observable activity; and measurable physiological, cognitive and emotional changes (Barker, 2014:38). Health-seeking behaviour encompasses the actions, thought processes and decision making involved in establishing and maintaining a healthy physiological state. This includes the prevention of; treatment and management of illnesses for individuals who identify as having a health-related problem (Latunji & Akinyemi, 2018:52; Oberoi, Chaudhary, Patnaik & Singh, 2016:463). The health-seeking behaviour of a community determines how health services are used and in turn, the health outcomes of populations (Musoke, Boynton, Butler & Musoke, 2014:1046). A populations' health-seeking behaviour is influenced by various individual and collective factors. Such factors include demographic, socio-economic, political and cultural factors of individuals and communities (Abongile, 2012:2).

Nayak, Sharada and Geroge (2012:61), emphasise that every society has its own traditional beliefs and practices related to health care, which are derived from traditional, cultural or religious practices. Some practices are effective, whereas others may be harmful or ineffective. These beliefs and practices are linked to culture, religion, environment and education within a community (Nayak et al., 2012:61). There is an increasing recognition within contemporary western medicine, of the significant links between spirituality, religion and health. Thus, there is a growing need for health professionals to understand their patient's spiritual belief practices, as this may impact their health-seeking behaviour (Rumun, 2014:39). In a country, such as South Africa, where there are numerous religious practices, including, Christianity and its sub-denominations- Reformed Christian, Anglican, Methodist, Lutheran, Presbyterian, Baptist, Roman Catholic, Charismatic and African Independent; Judaism; Hinduism; Buddhism and Islam (Schoeman, 2017:2). As a result of religion being a factor of health-seeking behaviour, it is important for professionals in the health sector to have an understanding of what factors in religion can affect health-seeking behaviour. For the purpose of this study, spiritual factors will be explored as these factors will influence the domains of among others, social behaviour, personality, emotion and health-seeking behaviour (Moleko, 2012:166).

The study focused on the spiritual factors influencing the health-seeking behaviour of the Charismatic Christians in Johannesburg, South Africa. The following are the key terms within the study:

Spiritual factors: Spiritual factors are the aspects directly linked to spirituality, this includes an understanding and experience with a higher connection, for example God influences the motivation, attitude, belief, judgement, practice of and behaviour directly linked to spiritual content or religious processes (Foy, Dresher & Watson, 2011:90). For the purpose of this study spiritual factors were those directly associated with Charismatic Christianity.

Health-seeking: Is the actions undertaken by an individual when engaging in a series of curative actions to recover from what they perceive as ill, this behaviour can be prohibited or encouraged through a variety of individual factors including spirituality and culture (Mahmood, Iqbal & Hanifi, 2009:69). With regards to this study, health-seeking referred to the specific actions taken by Charismatic Christians in Johannesburg, to ensure the prevention and treatment of illnesses.

Behaviour: Is the effort that are made by individuals to satisfy personal needs. These behaviours are purposeful and goal-directed with the main aim of satisfying perceived needs (Grobler, Schenck & Mbedzi, 2013:23). For the purpose of this study behaviour referred to the purposeful actions taken by charismatic Christians, in Johannesburg to satisfy their perceived health-related needs.

Charismatic Christianity: Charismatic Christians can be defined as Christian supporters who practice and are inspired by the word of God, the belief in Jesus of Nazareth and emphasises the powers of the Holy Spirit, including prophecy (Dein & Cook, 2015:98). For the purpose of this study, Charismatic Christians will refer to individuals in the Johannesburg region, who identify as, and practice the beliefs of Charismatic Christians.

1.2. THEORETICAL FRAMEWORK

The theoretical framework for the study included the social learning theory and the health belief model, as they guided the study through relevant theoretical knowledge, which assisted in building a strong theoretical foundation for the study. In the following sections, each theory will be discussed in terms of its origins, development and key theoretical assumptions.

1.2.1. Social learning theory

The study was grounded in the theoretical knowledge of the social learning theory, developed by Albert Bandura. Social learning theory will be discussed in terms of its development by theorists, theoretical constructs and is core principles.

1.2.1.1. Overview of the social learning theory

Social learning theory, also known as social-cognitive learning theory, was first suggested by Albert Bandura, who encompassed both behaviourist and cognitive principles to understand and explain the development of personalities (Cacioppo & Freberg, 2013:587). It is rooted in the basic concepts of traditional learning but has been adapted to focus on the occurrence of learning in the social environment (Chavis, 2011:472).

Social learning theory has continued its development since the 1950's and has been influenced by various theorists (Chavis, 2011:471). One of the major advocates, to date, is Ronald Akers who has proposed that the theory can be used to explain various types of behaviour, including devious behaviour (Pratt, Cullen, Sellers, Winfree, Madensen, Daigle, Fearn & Gau, 2010:768).

Albert Bandura (1971:3), theorised that new patterns of behaviour could be obtained through direct observation of the behaviours around us, or through direct experience of rewards or punishments, as a consequence of our own behaviour. Social learning theory can be seen as the mutual process of reciprocal determinism, whereby an individual learns social behaviour through a process of observing and imitating behaviour of their social environment (Cacioppo & Freberg, 2013:587; Chavis, 2011:472). Personality or social behaviour is further enforced through either a perceived reward to encourage the behaviour; or a punishment to deter the behaviour (Myers, 2013:363; Cacioppo & Freberg, 2013:587).

1.2.1.2. Learning through imitation and observation

Throughout communities it is evident that learning can occur through observation and imitation through the process of socialisation (Bandura, 1971:5). Imitation refers to using similar behaviour to others after the process of observation (Pratt et al., 2010:768). Through the process of socialisation, individuals will be exposed to the behaviour patterns of others, within the community - known as differential association - which helps an individual to define and prescribe to a certain behaviour (Pratt et al., 2010:768). With the presence of language, family, culture and religion, it is expected that certain behaviours will be taught based on the imitation of common role models, while other behaviours will be avoided due to the harm that befell others (Bandura, 1971:5). It is

suggested that this type of learning will be more prevalent if an individual sees themselves as being similar to the person they are observing and consequently, modelling (Deeming & Johnson, 2009:204).

1.2.1.3. Learning by direct experience

On a daily basis individuals are expected to make decisions when confronted by various situations. Through this direct experience, individuals will learn that certain responses result in favourable outcomes, while other responses may lead to less favourable or undesired outcomes (Bandura, 1971:3). Through the process of direct experience, individuals are able to learn which behaviour will result in desired outcomes. This type of learning will only occur when expectancies and reinforcement are present (Bandura, 1971:3; Williams, 2010:1).

Expectancies include those about environmental outcomes, personal actions and their outcomes and the competence needed to perform specific behaviours. This means that a particular behaviour will only be performed when, the person understands what event their action will lead to, the consequences of their personal actions and whether they have the competence to accurately perform this type of behaviour (Williams, 2010:1). Cognitive expectancy regarding outcomes, is determined by the individual's locus of control (Cacioppo & Freberg, 2013:587). An individual with an external locus of control will relate outcomes to chance, luck or misfortune, while those with an internal locus of control will relate outcomes to personal effort, or lack thereof (Cacioppo & Freberg, 2013:587).

Behaviour will be further enforced by reinforcement, either by rewarding a particular wanted outcome or by discouraging behaviour through consequences, known as differential reinforcement (Pratt et al., 2010:768). Differential reinforcement is the balance between expected rewards and anticipated consequences. A reward is likely to lead to repetitive behaviour whereas a negative consequence is expected to deter behaviour (Pratt et al., 2010:768).

Reinforcement can provide meaningful information regarding behaviour and consequences. An individual is able to receive meaningful information regarding the consequences that accompany behaviour, through the process of observation. The observed consequences can facilitate the creation of hypotheses that are most likely going to result in favourable outcomes for an individual (Bandura, 1971:3). Furthermore, through the experience of learning, individuals are also able to anticipate future outcomes and can adjust behaviour to receive a desired outcome or to alter behaviour to avoid an undesired outcome (Bandura, 1971:3).

Reinforcement is linked to self-efficacy, whereby the more competent an individual feels regarding a certain behaviour, the more likely they are to gain rewards for this behaviour in the future (Williams, 2010:2). Self-efficacy involves the perceptions that individuals hold regarding whether they feel capable of executing certain actions successfully (Bandura, 1977:43). As such, self-efficacy is situation dependent, as a belief in potential success comes from mastery of skills, meaning some individuals are more capable in certain situations than they are in others (Williams, 2010:2; Bandura, 1977:43).

1.2.2. Health belief model

The study further encapsulated the theoretical knowledge of the health belief model, which incorporated social learning theory beliefs. A brief overview regarding the development of the health belief model, with reference to its key elements, will be discussed.

1.2.2.1. Overview of the health belief model

The Health Belief Model was developed in the 1950's by social psychologists- Irwin Rosenstock, Godfrey Hochbaum, Stephen Kegeles and Howard Leventhal, who were members of the U.S. Public Health Service. They incorporated existing learning theories, such as the social learning theory to create a new model to understand health behaviour- the Health Belief Model (Champion & Skinner, 2008:46). These psychologists were working in public health and attempted to explain participation failure in prevention programmes and later the model was further developed to include health-seeking behaviour in response to symptoms and diagnosis (Champion & Skinner, 2008:46). The Health Belief Model is based on the premise that health related behaviour depends on motivation, vulnerability and benefit for an individual (Rosenstock, Stretcher & Becker, 1988:177). This entails that in order for a person to choose a specific health behaviour, they would need to experience a health concern, which they feel susceptible to and they would need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences (Rosenstock et al., 1988:177). If an individual views seeking healthcare as having more consequences than the health concern, health-seeking behaviours would be limited. If an individual, however, experienced seeking healthcare as having less consequences than the health concern, more health-seeking behaviour would be engaged in by the individual (Rosenstock et al., 1988:177). Furthermore, the health belief model stipulates that an individual is more likely to receive healthcare services if they believe that they have a vulnerability to a particular illness, especially if they view the illness as serious, and if they believe that health-seeking behaviour is more beneficial to them with fewer risks than benefits (Carpenter, 2010:663).

However, in some communities, health-seeking behaviours may be restricted due to population demographics, such as income and geographical area. This may result in a lack of health-seeking behaviour, even when an individual believes that they have a susceptibility to their health concern, or if they have perceived it as serious (Abongile, 2012:2). As such, it is important to understand that not only a perceived health concern is important in determining whether an individual will seek healthcare, as there are other factors involved that influence health-seeking behaviour. Thus, it is imperative that there is an understanding of all factors that affect health-seeking behaviour in order to eliminate barriers to timely and successful healthcare (Abongile, 2012:2).

1.2.2.2. Key elements

The health belief model encompasses four key elements: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. Perceived susceptibility refers to the subjective degree to which an individual feels vulnerable towards a specific illness or disease (Carpenter, 2010:663). Perceived severity incorporates the individual's subjective interpretation of the seriousness of the disease, they may feel the need to seek treatment or to forego treatment after an evaluation of the possible consequences (Rosenstock, 1974:330). Perceived benefits, which includes whether or not an individual views the recommended healthcare as feasible and beneficial, with less consequences than if they left the illness untreated (Rosenstock, 1974:331). Lastly, perceived barriers, which includes any negative consequences that health-seeking behaviour may incur, including expenses, effectiveness and level of danger. As such, this behaviour will only be engaged in when the benefits outweigh the risk factors (Carpenter, 2010:664).

The social learning theory and the health belief model are appropriate for the proposed study as both provide a theoretical framework as to how the cultural and spiritual factors of Charismatic Christians may be learned and internalised to influence health-seeking behaviours.

1.3. PROBLEM STATEMENT AND RATIONALE

Motives for conducting research include practice, theory, previous research, personal interest and intellectual curiosity (Fouché & De Vos, 2011:79). The problem statement serves to limit the focus of the study and clearly specify what it is that will be studied; it communicates to the reader what the study will include and what will be excluded, leaving the researcher with a singular question or hypothesis (Fouché & Delport, 2011:108).

Various studies from both international and national contexts have investigated how religion and culture affect health-seeking behaviours. This includes the health-seeking behaviours of

Charismatic Christians. These studies have found that health-seeking behaviour will be influenced by demographic, social and cognitive influences, including religious influences (Abongile, 2012:2). All religious groups have their own traditional beliefs and practices related to healthcare, some of which are effective, while others may be ineffective or harmful to the individual (Nayak et al., 2012:61). It is necessary to understand these beliefs to ensure that all healthcare service users practice effective health behaviours, while actively working to minimise those which are harmful or ineffective.

As was previously discussed, research has predominantly focused on health-seeking behaviours of Charismatic Christians in the mental health domain, in both an international and African context. To date, little research has been done into the general health-seeking behaviours of Charismatic Christians and indicates a possible gap for the proposed research study. This proposed gap in research, provides an opportunity to understand the health-seeking behaviours of Charismatic Christians in Johannesburg, by gaining an understanding of the actions, thought processes and decision making involved in the prevention of, treatment and management of illness (Latunji & Akinyemi, 2018:52). As health-seeking behaviour of a community determines how health services are used and in turn, the health outcomes of populations, it is necessary to understand the health-seeking behaviour of Charismatic Christians in Johannesburg, as this may indicate possible health outcomes and how health services are used. Both of which are important for providing effective healthcare (Musoke et al., 2014:1046).

There is an increasing recognition within contemporary western medicine of the significant links between spirituality, religion and health. Thus, there is a growing need for health professionals to understand their patient's spiritual belief practices and should be integrated into the community's cultural life (Rumun, 2014:39). The spiritual factors influencing health-seeking behaviours differ from one religion to another. Thus, in order to understand the health-seeking behaviours of Charismatic Christians in a South African context, a broader understanding of Charismatic Christianity in an African and global context will be necessary. Social workers in health care need to understand the cultural and spiritual context of their service users in order to understand their health-seeking behaviours. This will also help them to render appropriate intervention. Health-seeking behaviours have been researched, but a gap exists in the diverse spiritual factors influencing health-seeking behaviours of Charismatic Christians in a South African context.

The research question for this study is as follows: What are the spiritual factors influencing health-seeking behaviours of Charismatic Christians in Johannesburg, Gauteng.

1.4. AIM AND RESEARCH OBJECTIVES

The aim of this study was:

To explore the spiritual factors influencing health-seeking behaviours of the Charismatic Christians in Johannesburg, Gauteng.

The objectives were as follows:

To conceptualise and contextualise spiritual factors influencing health-seeking behaviour from a health belief perspective.

To explore and describe spiritual factors influencing health-seeking behaviour of Charismatic Christians in Johannesburg.

To make suggestions to improve social work services in healthcare, taking into consideration the factors influencing health-seeking behaviour among Charismatic Christians in Johannesburg.

1.5 OVERVIEW OF RESEARCH METHODOLOGY

The research paradigm which was utilised for the study was interpretivism to gain empathic understanding of the participants lived experiences within their particular historical setting (Neuman, 2014:103). The research paradigm informed the qualitative research approach. This approach was appropriate as it attempts to explain and interpret phenomena and the meanings that individuals associate with it, through rich, detailed descriptions (Lietz & Zayas, 2010:189).

The primary research purpose was exploratory, to gain insight into the spiritual factors of Charismatic Christianity that influence health-seeking behaviour as there is a lack of knowledge in this area of research within a South African context (Padgett, 2017:16). The secondary purpose was descriptive with the aim of obtaining rich descriptions about how the spiritual factors of Charismatic Christians influence health-seeking behaviour (Neuman, 2014:38).

The design used was the instrumental case study design. By using the instrumental case study design, insight was gained into the phenomenon of health-seeking behaviour which can be used to create recommendations to facilitate practice and refine theory to increase health-seeking behaviour (Nieuwenhuis, 2016a:82-83). The study was in depth and descriptive, using a data rich source from several participants to ensure that the research goal was obtained (Nieuwenhuis, 2016a:83).

The population included all South African citizens who are characterised as Charismatic Christians due to their beliefs and religious affiliation within the year 2020. The study population for this research study was adult Charismatic Christians residing in Johannesburg during the period of 2020 (Strydom, 2011a:223). Non-probability sampling was utilised as the odds of selecting a particular Charismatic Christian, residing in Johannesburg was unknown (Strydom & Delport, 2011:391). Firstly, volunteer sampling was used to ensure voluntary participation, in conjunction with purposive sampling was used as a Charismatic Christian church in the Johannesburg area was targeted to ensure a sample that met the inclusion criteria.

The method of data collection that was utilised was one-on-one interviews, an interview schedule and voice recordings of each interview, with the permission of participants, in an effort to collect data from participants to learn about their opinions, beliefs, viewpoints and behaviours, through a direct exchange between the participant and researcher. This was necessary to understand what and how spiritual factors of Charismatic Christianity influences health-seeking behaviour (Nieuwenhuis, 2016a:92; Greeff, 2011:342).

Thematic analysis was employed as the type of data analysis used for this study. This ensured that the researcher could identify, analyse and report patterns from the data regarding the spiritual factors that influence health-seeking behaviour (Vaismoradi, 2013:400). Thematic analysis incorporated the six phases of Braun and Clarke to ensure that an accurate process was followed. Data quality was ensured through the concept of trustworthiness which was ensured through four criteria: credibility, transferability, dependability and confirmability (Nieuwenhuis, 2016b:123).

A pilot study was conducted and served as a test for the data collection instrument, this allowed the researcher an opportunity to identify any potential problems that needed be corrected before the implementation of the actual semi-structured one-on-one interview (Christensen, Johnson & Turner, 2015:356). The pilot study was done using two participants, who were similar to those in the sample for the study (Christensen et al., 2015:285).

The ethical considerations of the proposed study included **avoidance of harm**, both physically and emotionally; (Strydom, 2011b:115). **voluntary participation and informed consent through a signed consent form.** Deception by the researcher was avoided and no compensation was provided to participants. Throughout the research process confidentiality, privacy and anonymity of participants were ensured where possible (Strydom, 2011b:115).

1.6. CONTENTS OF THE RESEARCH REPORT

Chapter one: General Introduction will include an introduction and contextualization of health, health-seeking behaviour and Charismatic Christianity. Chapter one will further include, an in-depth discussion of the theoretical framework used, namely- The health belief model and social learning theory. The problem statement and rationale will be discussed and linked to the research goal and purposes. Lastly, a brief overview of the chapters included in the research report will be provided.

Chapter two: Literature Review will present a literature review on the history, beliefs and practices of charismatic churches and the influence of religion on the health-seeking behaviours of Charismatic Christians, from a global, African and South African perspective.

Chapter three: Research Methodology and Empirical Study will include an outline of the research approach, type and design used to implement the study, including the sampling, data-gathering and data-analysis techniques and pilot study that will be used. Also, the ethical considerations that were adhered to will be discussed. The second section will focus on the research findings of this study and provide a detailed interpretation thereof through the process of thematic analysis.

The final chapter, **Chapter four: Conclusions and Recommendations,** will discuss the achievement of the goal, objectives and research question, as well as the key findings. Using the key findings, conclusions and possible recommendations for practice and future research.

Chapter two follows with the literature study.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

In order to gain an understanding of the spiritual factors affecting the health-seeking behaviour of Charismatic Christians in Johannesburg, the literature review will explore general health-seeking behaviours, involving the actions and thought processes an individual with a perceived illness will partake in (Oberoi et al., 2016:463). As each society has its own traditional beliefs and practices related to health care, the literature review will aim to find these differences in both international and national studies, thus providing both, critical information from previous studies, as well as, highlighting the gap in research regarding health-seeking behaviour (Nayak et al., 2012:61). For the purpose of this study, spiritual factors will be explored as these factors affect health-seeking behaviour, thereafter Charismatic Christianity will be discussed in-depth, to provide insight into the health-seeking behaviour of Charismatic Christians (Moleko, 2012:166).

The literature review will provide an overview of health within a South African system, with a focus on health trends and the general health care system. Furthermore, it will highlight health-seeking behaviour with a focus on defining health-seeking behaviour and describing the factors and approaches that affect health-seeking behaviour. Lastly, the literature review will provide an in-depth discussion regarding Charismatic Christianity and the known health-seeking behaviours and health beliefs of Charismatic Christians.

2.2. OVERVIEW OF HEALTH IN SOUTH AFRICA

Health in a South African context is a complex phenomenon, encompassing health trends, the health status of citizens and the types of healthcare available to South Africans. To gain an understanding of health in South African the health status of South Africans, accompanied by South Africa's prominent health trends will be discussed. Furthermore, an in-depth discussion consisting of the types of treatments available in South Africa, will be provided. This includes primary healthcare, allopathic healthcare, complementary and alternative medicine and indigenous and traditional medicine. Lastly, a brief overview will be provided regarding the global health trends, to gain a better understanding of how South Africa aligns with global health trends.

2.2.1. Defining health

Health is defined as a person's well-being, with regards to there being a balance between an individual's physical, mental and social well-being. As such, health implies that there is an absence of illness and disease (Taylor, 2015:3; Bircher & Kuruvilla, 2014:365). Illness and disease do not only incorporate physical aspects, but also include mental aspects that affect the well-being of an individual (Van Rensburg, 2012:4). Health further includes an individual's ability to recover from illness due to treatment and rehabilitation, as well as the ability to adapt to new health threats (Felman, 2017). This ability to adapt, includes individuals with chronic illnesses, as they do not have the ability to be cured. As such, health includes the resilience and capacity of an individual to cope and adapt to chronic illness so that the balance of well-being is restored (Bircher & Kuruvilla, 2014:365). An individual's health is unique as health is affected by a variety of factors, including, but not limited to, genetics, environmental factors, social factors and economic factors (Taylor, 2015:29; Felman, 2017).

2.2.1.1. Physical health

Physical health refers to the physiological functions of the human body that are able to work together as a system to meet the needs of the body (Felman, 2017; Bircher & Kuruvilla, 2014:365). Physical health implies that there is no disease, illness or deformity to the physiological aspects of the body, however, due to the increase in knowledge and technological advances in medicine, physical health can also imply the body's ability to adapt and maintain well-being (Bircher & Kuruvilla, 2014:365).

Physical health can be maintained by preventing disease or injury that affects the body. There are various methods of prevention, such as exercise, accident prevention, developing a healthy diet, healthy sleeping patterns and preventative procedures such as, vaccinations, sun safety and regular mammograms or other screening tests (Taylor, 2015:64). Physical health can also be restored through treatment and rehabilitation methods that are uniquely designed to target a specific physiological dysfunction or abnormality (Felman, 2017). Lastly, for individuals with chronic physiological disorders treatment and rehabilitation methods that are not curative but aim to restore and maintain well-being can be employed. For example, a paraplegic individual can restore functioning with a wheelchair, physiotherapy and occupational therapy, to adapt to new circumstances in order to achieve their daily goals and tasks (Bircher & Kuruvilla, 2014:365).

2.2.1.2. Mental health

Mental health is related to all aspects of health regarding an individual's emotional, social and psychological well-being (Felman, 2017). Unlike with physical health, there are no biological tests that can prove a mental illness (although with advances in medicine, some testing methods may help in diagnosing individuals). Instead, professionals in the mental health field view mental illness as a collection of problems regarding cognition, regulation and social behaviour (Nolen-Hoeksema, 2013:5). As such mental illnesses are categorised through the use of a diagnostic tool that indicates a mental illness based on a collection of dysfunctions (Nolen-Hoeksema, 2013:5). It is important to note that mental health is not only the absence of mental illness, such as depression, but also an individual's ability to adapt, cope, achieve goals and to experience a sense of safety and security (Felman, 2017).

Mental health is restored and maintained through the modern mental healthcare system. This system is focused on patients' rights, meaning that their wants and needs are taken into account and they are treated with dignity and worth. As such, fewer individuals are admitted into institutions, instead, those that are able to, are reintegrated into society for community care (Nolen-Hoeksema, 2013:16). Furthermore, psychiatrists, clinical physiologists, marriage and family therapists, social workers and psychiatric nurses, work together in a multi-disciplinary team, to ensure that individuals with mental illnesses are treated with medications and that their capacity and coping techniques are strengthened, in order to restore and maintain mental well-being and daily functioning in society (Nolen-Hoeksema, 2013:19; Taylor, 2015:3).

2.2.1.3. The interrelationship between physical and mental health

Individuals with poor mental health are more likely to present with physical health disorders than those with good mental health and vice versa (Nolen-Hoeksema, 2013:438). This is seen for example in an Australian study conducted by Kemp and Quintana (2013: 288), that found that individuals who suffer from depression are more likely to suffer from cardio-vascular disorders. These individuals are more likely to develop a cardio-vascular disorder, furthermore, individuals with a pre-existing cardio-vascular condition are more likely to suffer future attacks or health problems if they are diagnosed with the co-morbidity of depression (Kemp & Quintana, 2013:288).

In some cases, mental health problems can be seen as the leading cause of a physical health disease (Taylor, 2015:7). For instance, substance abuse disorders can cause hypertension, kidney and liver damage; diet or smoking can lead to cancer or heart disease; or anorexia nervosa can cause osteopetrosis due to lack of nutrients (Nolen-Hoeksema, 2013:438; Taylor, 2015:7).

Mental health problems can also act as an impediment to restoring balance and functioning to individuals with physical health problems (Taylor, 2015:7). Individuals with chronic physical health problems need psychological and social assistance to adjust and maintain well-being (Taylor, 2015:7). As such, individuals with mental health problems will have limited cognitive, regulative and social skills needed to successfully cope with and function in everyday life (Nolen-Hoeksema, 2013:438). Due to this impediment, individuals will be less likely to engage in health management behaviours (Taylor, 2015:7).

Due to the interrelationship between mental and physical health, it will be necessary to treat individuals as part of a multi-disciplinary team. As early diagnosis of either disorder will improve the individual's overall prognosis (Kemp & Quintana, 2013:288).

2.2.2. Defining healthcare

Healthcare consists of the efforts made by healthcare workers to restore an individual's physical, mental or emotional well-being (Merriam-Webster, 2019). In South Africa healthcare practices include traditional medicine, alternative medicine and allopathic medicine as a form of treatment to restore well-being (Abaerei, 2016:3). As such healthcare settings include self-treatment, traditional healers, government health care settings, as well as private healthcare practices or practices involving alternative medicine (Abaerei, 2016:3).

There are three levels of formal healthcare services, namely: primary, secondary and tertiary healthcare. Primary healthcare is an approach to health care that focuses on first level care and is promoted by the South African healthcare system, it places emphasis on multi-sectoral team collaboration and community involvement (Engelbrecht & Van Rensburg, 2012:483). The goal of primary healthcare is prevention and screening for early detection of diseases within communities (Engelbrecht & Van Rensburg, 2012:483). Secondary healthcare is defined as specialised hospital services that provide services of medium complexity. Such services include basic medical services, diagnostic services, therapeutic support services and emergency services (Erdmann, De Andrade, De Mello & Drago, 2013:133). Lastly, tertiary healthcare services include all highly specialised medical services. Tertiary healthcare is the most expensive form of healthcare and can be provided through government facilities or through private healthcare, within the South African system (South African Government, 2019). Tertiary healthcare involves medical specialists, advanced medical investigations and appropriate treatment and rehabilitation methods (South African Government, 2019).

2.2.3. Current health status and trends

Mortality and morbidity indicators provide insight into the health status of a country, as such reference will be made to both indicators in order to ensure a well-informed understanding of South Africa's health status as compared to the global statistics (World Health Organisation (WHO), 2009:35). Mortality indicators refers to the number of deaths, within a specific region and time period, and is measured per 1000 people (WHO, 2019). Morbidity indicators refers to any diseases, injuries or disabilities within a specific region and time period and is measured per 1000 people (Redelinghuys, 2012:241).

Globally, 20% of all deaths are those of children under the age of five years, in low-economically developed countries a high child mortality rate is more prevalent than in more economically developed countries (WHO, 2009:35). An example of this is that in 2007, the African continent had a child mortality rate of 145 per 1000 live births, whereas, the America's had a child mortality rate of 19 per 1000 live births (WHO, 2009:35). In more recent years, there has been a decline in the child mortality rate of African countries (WHO, 2009:35). As with child mortality rates, a higher mortality rate can be seen in underdeveloped countries. For instance, the global mortality rate is 180 per 1000 people, in Europe is it 149 per 1000 people and in Africa it is 392 per 1000 people (Redelinghuys, 2012:253). This pattern may be as a result of poorer living conditions in less developed countries, leading to poor hygiene and sanitation, overpopulation, malnutrition, pollution and the lack of access to resources (Redelinghuys, 2012:253). As with child mortality rates, a decline in the overall mortality rate can be seen globally. This may be due to advances in medical technology, research, treatment and improved living standards that encourage education and access to resources (Redelinghuys, 2012:247-248).

Morbidity indicators show a global trend of common, prevalent causes of death. Globally, non-communicable diseases account for 71% of all deaths. The non-communicable diseases morbidity rate is currently as follows: 44 % of deaths are attributed to cardiovascular disease, 22% of deaths are caused by cancer, 9% is due to respiratory infections and 4% of non-communicable disease deaths are caused by diabetes (WHO, 2018a:7). Furthermore, common global communicable diseases with high morbidity rates include diarrhoeal diseases, HIV and AIDS, and Tuberculosis (TB). These causes of death are especially high in African regions and regions with high rates of poverty (WHO, 2018a:5-6). Trends in morbidity follow a similar pattern to the mortality indicator, as socio-economic development affects the most prevalent causes of death in a country. For countries with a low socio-economic development, morbidity rates are the

highest for communicable diseases such as, lower respiratory infections, diarrhoeal disease and HIV and AIDS (Redelinghuys, 2012:251). Whereas, in highly developed socio-economic countries, cerebrovascular diseases, such as stroke, and coronary heart disease are leading causes of death (Redelinghuys, 2012:252).

In contrast to the global statistics, South Africa's leading causes of natural deaths (88,5%) was attributed to Tuberculosis (6,4%), Diabetes Mellitus (5,7%), Cerebrovascular diseases (5%), other forms of heart disease (4,9%) and HIV and AIDS (4,8%) (Statistics South Africa (STATS SA), 2017:29; 36). Other leading causes of death in South Africa, include hypertensive diseases, ischaemic heart diseases, respiratory disease, as well as non-natural causes of death (11,5%), including, injuries, assault and transport accidents (STATS SA, 2017: 29; 36; 48).

South Africa is currently experiencing a phenomenon known as the double burden of disease. This phenomenon is described as a country who is experiencing an increase in chronic, non-communicable diseases, such as diabetes and coronary heart disease, in conjunction with the spread of communicable diseases, such as TB and HIV and AIDS (Kushitor & Boatemaa, 2018:1). Currently, South Africa is experiencing an increase of chronic diseases and infectious diseases within the population, which is further enhanced by the large numbers of people living in poverty (Abaerei, 2016:2; Abongile, 2010:1). This has increased the need for individuals to seek formal healthcare, however, due to the various factors influencing health-seeking behaviour, many South Africans may not receive this care. It is important to note, that not only those living in poverty experience the burden of these diseases, thus further influencing the importance of understanding health-seeking behaviour (Abaerei, 2016:2; Abongile, 2010:1). The common disease profile in South Africa includes HIV/AIDS, tuberculosis, malaria, hypertension, cardiovascular and respiratory diseases, diabetes and cancer (Redelinghuys, 2012:267).

2.2.3.1. The profile of communicable diseases in South Africa

South Africa's current profile for the most prevalent communicable diseases, includes: TB, malaria, measles and HIV and AIDS. Various programmes and initiatives have been implemented to reduce the burden of communicable diseases in South Africa. These diseases are often related to under-development and poverty experienced in South Africa, as there is less access to resources, poor nutrition, poor hygiene and over-crowding (Redelinghuys, 2012:269). As the spread of HIV and TB are linked to community beliefs, including spiritual factors, they will be discussed in more detail below to understand how these factors influence the disease profile in South Africa.

- **HIV and AIDS**

Acquired Immune Deficiency Syndrome (AIDS) is acquired through contracting the human immunodeficiency virus (HIV). The virus weakens the body's immune system which disables it from protecting the body from communicable diseases and infections (Centers for Disease Control and Prevention (CDC), 2019). Furthermore, AIDS can be defined as a syndrome whereby opportunistic communicable diseases are acquired, further weakening the body and possibly leading to death (CDC, 2019).

South Africa is currently experiencing an epidemic of HIV and AIDS with a prevalence rate of 16,9% for South Africans 18 years and older and 13,1% of all South Africans, with 1 fifth of South African women being infected (Statistics South Africa (STATS SA), 2018:7; Redelinghuys, 2012:276). The prevalence of HIV in South Africa is said to be heightened, due to the current socio-economic status of South Africans. Currently, the socio-economic status of South Africa is characterised by poverty, migrant labour, inequality, violence against women and cultural and spiritual beliefs and values (Redelinghuys, 2012:276).

As HIV is incurable and progression of the disease can only be slowed down through the use of anti-retroviral's (ARV's), it is imperative that the spread of HIV be curbed. In order to achieve this goal, it is necessary to understand the spiritual beliefs regarding healthy sexual behaviour, which is an aspect of behaviour related to health and health-seeking behaviour (Redelinghuys, 2012:276). A study conducted in Sub-Saharan Africa, by Idele, Gillespie, Porth, Suzuki, Mahy, Kasedde and Luo (2014: 147), found that most new cases of HIV are due to sexual transmission, with a decrease in mother-to-child transmissions. This study further found that less than half of the adolescents who participated in the study had basic knowledge regarding HIV. A further way to combat the spread of HIV is through education and improving knowledge regarding the link between risky-sexual behaviour and HIV, as well as, correcting the misconceptions regarding HIV that were obtained from various belief systems, including spiritual beliefs (Idele et al., 2014:147).

- **Tuberculosis (TB)**

TB is a communicable disease which is caused by a highly infectious bacteria that enters and affects lung tissue (Taylor, 2015:24-25). Due to the development of tubercle masses in the lungs, TB can cause scar tissue and disrupt the process of oxygen and carbon dioxide exchange (Taylor, 2015:25). If left untreated TB can cause pain, permanent damage to the lung tissue and ultimately, death.

South Africa currently has the third highest prevalence rate of TB in the world, which contributes to 13% of the South African death rate (Redelinghuys, 2012:273). One theory is that the prevalence rate of TB is so high due to the high HIV rate in the country, as a large portion of the population live with weakened immune systems, it is easier to contract TB, especially in overcrowded populations (Redelinghuys, 2012:274). A major concern for healthcare workers in South Africa, is the high incidence rate of patients being diagnosed to multi-drug resistant TB, which means that the TB bacteria is unable to be effectively controlled and is easily spread to the community (WHO, 2018b). One method of ensuring that TB does not become drug resistant, is the proper administration and management of TB medications, which is often hindered by a community's belief systems, such as their spiritual beliefs regarding health, healthcare and health-seeking behaviour (WHO, 2018b).

2.2.3.2. The profile of non-communicable diseases in South Africa

Non-communicable diseases, which are usually linked to the lifestyle of South Africans, include: circulatory and respiratory diseases, diabetes and cancer. Non-communicable diseases are often chronic, lasting for several years or until death. These diseases are often life-threating, especially if left untreated (Kushitor & Boatemaa, 2018:2). As non-communicable diseases are often due to lifestyle choices and may be influenced by spiritual belief systems, it is necessary to discuss some prevalent diseases which may affect global health trends, as well as South African communities.

The non-communicable diseases with the highest prevalence will be discussed below.

- **Circulatory diseases**

Circulatory diseases are those that affect the cardiovascular system, including the heart and blood vessels (Taylor, 2015:20). The South African population is most affected by ischaemic heart diseases and cerebrovascular diseases. Ischaemic heart disease is a common global disorder, characterised by a decrease of oxygenated blood flow to the heart muscle, as a result of coronary arteries that become narrowed or blocked (Taylor, 2015:22; Verschuerena, Eskes, Maaskant, Roest, Latour & Reimer, 2018:80; British Heart Foundation, 2017; Gilani & Afridi, 2017:209). Ischaemic heart disease is a leading cause of death for White (most prevalent) and Indian (third most prevalent) South Africans (Redelinghuys, 2012:279). Cerebrovascular disease, otherwise known as a stroke, is presented as neurological symptoms resulting from a haemorrhage or due to blocked arteries in the nervous system (Kraft, 2019). Cerebrovascular disease can develop from atherosclerosis, where the arteries become narrow; and from thrombosis or blood clots in arteries or veins of the brain (Kraft, 2019). If a blockage, damage to the structure of the brain or

a haemorrhage occurs, the result can be varying degrees of brain damage or death (Kraft, 2019). Cerebrovascular disease is the third most common death for White and Coloured South Africans and the fourth most common for Indian South Africans (Redelinghuys, 2012:279).

- **Respiratory diseases**

Respiratory diseases affect the respiratory system and reduce the ability to take in oxygen, excrete carbon dioxide or regulate the composition of the blood (Taylor, 2015:23). In South Africa one the highest prevalence rates of respiratory diseases is asthma. Asthma can be described as an allergic reaction to a foreign substance that enters the body through the respiratory system, it can also be worsened by emotional stress and exercise (Taylor, 2015:24). During an asthma attack, air tubes constrict and swelling or inflammation can occur. During a serious attack hyperventilation and bronchial spasms may occur, which causes difficulty breathing and emotional distress (Taylor, 2015:24). In South Africa a prevalence rate of 16 per 1000 people can be found, with White males and Coloured females being the most affected (Redelinghuys, 2012:280). Asthma is perpetuated by a mixture of environmental and socio-economic factors. The combination of air pollution and the use of wood, paraffin and coal as a source of heating and cooking in poor communities, contribute to the high prevalence of Asthma in South Africa (Redelinghuys, 2012:280).

- **Diabetes Mellitus**

Diabetes is a medical condition, which is characterised by elevated glucose levels, as a result of the body not producing enough insulin (Nall, 2018). Type II diabetes is caused from lifestyle choices related to socio-economic factors and cultural beliefs and can be avoided through healthy lifestyle choices (Nall, 2018). In South Africa, the prevalence of diabetes has increased slightly over recent years and is higher among persons aged over 45 years (Redelinghuys, 2012:280). There appears to be a link between culture and diabetes, as the prevalence in Indian and White male populations is the highest, while diabetes is the least prevalent in both black male and female population groups. However, due to the nature of diabetes, as obesity increases among all population groups, it is likely that diabetes prevalence will also increase (Redelinghuys, 2012:281).

- **Cancer**

Cancer is a non-communicable disease that results from a DNA dysfunction, which causes rapid cell growth that deteriorates the body's resources. Cancer can occur anywhere in the body, with varying degrees of treatment success (Taylor, 2015:287). Although there is a genetic component

involved in most forms of cancer, researchers believe that certain environmental and socio-economic factors can also contribute to the prevalence of cancer, such as, smoking, a fatty diet, alcohol consumption, high levels of stress and poor emotional regulation (Taylor, 2015:288-289). In South Africa, the older population is more at risk of developing cancer, as well as those with compromised immune systems (Redelinghuys, 2012:282). Cancer is also found to be higher for those living in urban areas than in rural areas and has the highest prevalence in the White population of South Africans (Redelinghuys, 2012:282).

2.2.4. Healthcare in South Africa

Within the South African context there are both formal and informal healthcare facilities, South Africans also engage in self-care, alternative and complementary medicine, as well as visits to traditional healers. These routes may be seen as impediments towards formal health-seeking behaviours (Abaerei, 2016:3). As South Africa is a developing country the main types of healthcare settings that are used by the population include: self-treatment, traditional healers and government healthcare settings, as well as private healthcare settings or practices involving alternative medicine (Abaerei, 2016:3). The decision to engage in any of the aforementioned treatment methods is influenced by factors which will be discussed in the section regarding health-seeking behaviours.

In South Africa due to a low percentage of medical aid schemes within the population, the government is burdened with the high use of public health services, which may affect access and availability to services, as well as the standard of services provided (Abongile, 2010:71). The government thus encourages the use of primary healthcare, to prevent medical complications and allopathic medicine to treat medical complications. Due to the large number of spiritual groups, with various beliefs within South Africa, many South Africans may also engage in alternative and complimentary medicine, as an alternative to allopathic medicine.

2.2.4.1. Allopathic medicine

Allopathic medicine is the main form of medicine which is utilised in the western world, it is also practised in Africa and the East. Allopathic medicine, although majorly a western form of medical practice, has its roots in Chinese, European, Middle Eastern, American and North African medicine and medical knowledge (Pretorius, 2012:594). Allopathic medicine was first introduced to South Africa throughout the period of colonialisation. It became the belief of the colonisers that traditional medicine was a form of witchcraft, as such it was banned, and allopathic medicine became the only form of publicly practiced medicine. This law was later abolished, and alternative

forms of medicine started to gain popularity; however, allopathic medicine remains one of the most utilised forms of medicine in South Africa, especially in urban areas (Nemutandani, Hendricks & Mulaudzi, 2016:1).

The foundation of allopathic medicine is that the knowledge and belief systems of allopathy must always be empirically proven, rationalised and organised through research (Pretorius, 2012:594). Allopathic medicine originated with the purpose of identifying, treating and eradicating diseases. In order to achieve its purpose, allopathic medicine incorporates the use of medication, surgery, rehabilitation services or a combination thereof (Pretorius, 2012:594). Today, allopathic is still the most widely practised form of medicine in South Africa, in both the government and private sectors. It aims to identify new diseases and effective treatment methods to ensure its original purpose. Furthermore, allopathic medicine is used in the research and treatment of communicable and non-communicable diseases to reduce the burden of disease (Pretorius, 2012:594).

2.2.4.2. Alternative and complimentary medicine

Complementary and alternative medicine (CAM) and integrative or natural medicine originates from the concept of holistic medicine. Holistic medicine focuses on the physical, psychological and spiritual needs of a person, believing that all aspects must be in harmony to ensure the health of a person, thus all aspects of health are considered (Taylor, 2015:182; Center for Integrative Medicine, 2016). CAM is a diverse group of medical treatments which includes prayer, potions or natural medication, meditation, yoga and acupuncture, among many others (Taylor, 2015:182). These methods are a non-biomedical health care approach, meaning that allopathic medicines, surgeries, treatment methods and rehabilitation procedures are not used in the treatment of illnesses (Pretorius, 2012:596). Integrative or natural medicine is the use of allopathic or alternative treatments, but only to the point of treatments remaining non-invasive, thus a more natural process is applied (Center for Integrative Medicine, 2016).

CAM approaches to healing are often performed as an aspect of religious and secular care, thus are influenced by spiritual belief systems (Pretorius, 2012:596). Throughout history, this type of medicine was practiced by religious and cultural leaders but was not seen as valuable by qualified professionals. In recent years, however, CAM has become more recognisable, and some merit is seen in approaches (Pretorius, 2012:597). Moreover, CAM is now generally practiced by trained professionals and can be used as a complimentary treatment that corresponds with allopathic medicine (Pretorius, 2012:598).

2.2.4.3. African indigenous and traditional medicine

African indigenous or traditional medicine focuses on restoring the physical or mental functioning of an individual, furthermore, it aims to diagnose, treat or prevent physical and mental illnesses (Traditional Health Practitioners Act 22 of 2007:7). Traditional medicine assists with rehabilitation of an individual into their family and community to ensure acceptance and functioning within the community (Traditional Health Practitioners Act 22 of 2007:7). Lastly, traditional medicine is used to aid in the preparation of life events e.g. puberty, pregnancy and death, within a particular culture or spiritual belief system (Traditional Health Practitioners Act 22 of 2007:7). There are different types of traditional healers, who perform different functions. Such categories include diviners, herbalists, traditional birth attendants, traditional surgeons and faith healers. All traditional healers only become so after a calling and subsequent apprenticeship or training (Pretorius, 2012:624; Traditional healer, 2013).

As previously mentioned, in South Africa traditional medicine was seen as witchcraft and its practice was subsequently banned (Nemutandani et al., 2016:1). Today, this is no longer the case and traditional medicine is practiced freely by many cultural and religious South African groups (Pretorius, 2012:624; Nemutandani et al., 2016:2). Traditional medicine can be used in conjunction with allopathic medicine and have favourable results, as the bio-psycho-social aspects of a person are met (Nemutandani et al., 2016:2). Despite this, the manner in which traditional medicine is utilised in South Africa is concerning, as it has been found that many African communities self-refer to traditional healers and do not seek treatment from any allopathic professional, which in some cases provides the only successful treatment for illnesses (Nemutandani et al., 2016:2).

2.2.4.4. Primary Health Care

Primary health care (PHC) is an approach to health care that focuses on first level care and is promoted by the South African healthcare system. PHC places emphasis on multi-sectoral team collaboration and community involvement (Engelbrecht & Van Rensburg, 2012:483). There are various members involved in PHC, which include the allopathic multi-disciplinary team members, politicians, engineers, architects, sanitation specialists, educators and many skilled professionals can be used to ensure the success of PHC (Engelbrecht & Van Rensburg, 2012:483). The government is a key role player in ensuring that PHC is successful in South Africa. In order for PHC to be successful, their equal access to PHC must be ensured, services and resources must

be accessible and affordable, thus special consideration should be made for those living in poverty and rural communities (De Ryhove, 2012).

As the South African government provides healthcare services to the majority of the country, their services and resources are over-utilised, causing a depletion in available resources (Abongile, 2010:71). As such, the South African government aims to promote health and prevent disease, through educational efforts. This promotion of healthy living standards should reduce the prevalence of both communicable and non-communicable diseases, which in turn, should reduce the burden on South Africa's healthcare system (Engelbrecht & Van Rensburg, 2012:484).

Social workers who practice within the health-care domain should be aware of the factors that influence health-seeking behaviour, as this can be incorporated into service delivery strategies that maintain sensitivity towards the diverse client system. Within the following section, health-seeking behaviour will be discussed, with specific reference to the approaches to, and the factors affecting health-seeking behaviours.

2.2.5. Health promotion

Health promotion is a key initiative in primary healthcare and encompasses preventative measures in an individual's everyday lifestyle to maintain a status of health (Taylor, 2015:39). Health promotion is a systematic process and is rooted in science and research, however, despite this not all individuals engage in health promoting behaviours. As such, community mobilisation, action plans and policy reform are incorporated to motivate and mobilise communities (Sharma, 2016:10).

Broadly, health promotion is seen as a planned initiative, which includes political, organisational and educational actions, with the aim of maintaining well-being in a community (Sharma, 2016:10). For an individual, health promotion includes developing healthy living habits, which include aspects such as sufficient exercise; general safety procedures, such as wearing a seatbelt; early detection or preventative methods, such as mammograms or vaccinations; a balanced diet; as well as sufficient sleep and stress, reducing or relieving practices (Taylor, 2015: 39, 64). Due to a lack of sufficient knowledge regarding healthy behaviours, members of medical multi-disciplinary teams are tasked to provide education on individual and community levels, as well as, helping at risk individuals monitor and reduce risks (Taylor, 2015:39).

Health promotion is generally not a voluntary process, although in some cases it can be. Usually, individuals are persuaded or forced to adjust their behaviour due to measures or regulations, put

in place to promote health behaviours (Sharma, 2016:10). For instance, individuals are more likely to stop smoking if taxes are placed on cigarettes or pictures of cancers are placed on the box to invoke fear, however, since the conception of health promoting behaviours many techniques and strategies have been employed (Taylor, 2015:45; Sharma, 2016:10).

2.3. OVERVIEW OF HEALTH-SEEKING BEHAVIOUR

Health-seeking behaviour can be defined as the actions that individuals partake in; and the attitudes that individuals hold regarding health and illness, to recover from what they perceive as ill. This is usually in the form of health care services and treatment methods; however, it can also include daily living to ensure a healthy lifestyle (Abaerie, 2016:1; Abongile, 2010:1). Health-seeking behaviour can also be seen as the actions that individuals engage in to prevent and treat perceived illnesses; this will be influenced by a variety of factors which will be discussed in the following section regarding health-seeking behaviours.

2.3.1. Defining health-seeking behaviour

Health-seeking behaviour is the actions that are undertaken by an individual, during which they engage in a series of curative actions to recover from what they perceive as ill (Mahmood, Iqbal & Hanifi, 2009:69). As is consistent with the definition of behaviour, these actions are taken to satisfy personal needs, in this case, the need to remain or gain perceived health (Grobler, Schenck & Mbedzi, 2013:23). As such, health-seeking behaviour will always be purposeful and goal-directed in order to satisfy these needs (Grobler et al., 2013:23). Certain health-seeking behaviours can be prohibited or encouraged through a variety of individual factors, such as spirituality (Mahmood et al., 2009:69).

Health-seeking behaviour can be seen as an endpoint, meaning that only once an individual has perceived themselves as ill, will they seek health care services, with the sole purpose of seeking treatment to recover from their perceived illnesses (Abaerie, 2016:1). During this time, individuals will generally consult formal health care institutions to ensure recovery from their perceived illness (Abongile, 2010:2). Secondly, health-seeking behaviour can be seen as a process, from a psychological perspective and views what inhibits or encourages health-seeking behaviours. This approach incorporates lifestyle choices, as well as medical treatments (Abongile, 2010:2; Ogden, 2012:7).

2.3.2. Approaches to health-seeking behaviour

There are two main approaches that an individual can partake in regarding health-seeking behaviour. Firstly, health-seeking behaviour is often only engaged in after an illness has developed and not as a part of general healthy living (Abaerie, 2016:1). This means that only after an individual has perceived themselves as ill, will they seek health care services to treat and recover from perceived illnesses (Abaerie, 2016:1). During this time, individuals will generally consult formal health care institutions to ensure recovery from their perceived illness (Abongile, 2010:2). Although, alternative or indigenous forms of medicine are also utilised for treatment, allopathic medicine remains one of the most utilised forms of medicine in South Africa, especially in urban areas and with more serious forms of illness (Nemutandani et al., 2016:1). This is due to the fact that alternative forms of medicine do not include surgeries, treatment methods and rehabilitation procedures which may be necessary in the treatment of a perceived illness (Pretorius, 2012:596). In a study conducted with Danish citizens, Friis, Lasgaard, Osborne and Maindal (2016:8) found that individuals were more likely to engage in health-seeking behaviours if they understood health information. It was further reported that individuals with long-term conditions reported a lack of understanding health related information and were therefore less likely to engage in formal healthcare (Friis et al., 2016:8). As such, although individuals are more likely to engage in health-seeking behaviour once symptoms are present, there are individuals who delay this behaviour due to a lack of understanding, which is influenced by many factors and will be discussed further in this chapter.

A second approach to health-seeking behaviour, is that health-seeking behaviour can be seen as a process. This approach is from a psychological perspective and views what inhibits or encourages health-seeking behaviours. Thus, the approach incorporates lifestyle choices, as well as medical treatments (Abongile, 2010:2; Ogden, 2012:7). Behaviour patterns regarding health will be individually established based on psychological factors, which are influenced by cultural and spiritual beliefs, socio-economic status, the individual's perceptions of illness, health and treatment options available (Ogden, 2012:7). Furthermore, the approach considers predisposing factors, such as gender and age; enabling factors, such as finances and medical aid; and treatment factors, such as available healthcare services (Abongile, 2010:2). This is necessary as predisposing factors work in conjunction with psychological factors to influence health-seeking behaviours (Abongile, 2010:2; Ogden, 2012:7). In a study conducted by Deasy, Coughlan, Pironom, Jourdan and McNamara (2014:85) in Ireland among university students, it was found that although aware of lifestyle choices that promote healthy behaviours and encourage healthy

living, many individuals engaged in several behaviours that negatively impacted health. These included lack of exercise (26%), unhealthy diets (26.3%) and engaging in risky behaviours, including alcohol consumption (93.2%), smoking (17%) and cannabis (11.6%) use. As such, this form of health-seeking behaviour emphasises individuals' choices and thus, engagement in behaviour may differ from individual to individual.

This form of health-seeking behaviour does not only occur after an illness is perceived but may also include behaviour and decisions made in general healthy living. As such, alternative medicine will often be incorporated, as this is a form of holistic medicine focusing on physical, psychological and spiritual needs (Taylor, 2015:182; Center for Integrative Medicine, 2016). In South Africa traditional medicine has also gained popularity and may also be utilised in the approach, as it focuses on restoring the physical or mental functioning of an individual (Traditional Health Practitioners Act 22 of 2007:7).

For the purpose of this study the second approach will be considered to better understand the spiritual factors that contribute to health-seeking behaviour.

2.3.3. Factors influencing health-seeking behaviour

Health-seeking behaviour is influenced by cultural, political, demographic, physical and socio-economic factors, relating to individual persons (Abongile, 2012:2). Several studies have been conducted, on both a national and international level, regarding the factors that influence health-seeking behaviour. Despite this, several gaps exist in literature, as most of these studies investigate the factors that delay or hinder seeking health services, with a focus on third world countries.

The multitude of medical channels available in South Africa, such as formal institutions, traditional healers and alternative medicine has affected health-seeking behaviour in South Africa. The type of medical assistance that users engage in, is dependent on factors such as socio-economic status, demographic factors and politics (Pelser, 2012:227).

2.3.3.1. Individual factors influencing health-seeking behaviour

An individual factor to health-seeking behaviour, is linked to the notion that all individuals have the common desire to live a long life. As such, individuals are more likely to seek healthcare if they feel that this desire is threatened (Bircher & Kuruvilla, 2014:370). Furthermore, individuals are more likely to engage in health-seeking behaviour if they have experienced symptoms over a

long period of time, or if they experience several symptoms at the same time (Musoke et al., 2014:1051).

Furthermore, individuals appear to engage in a process of self-care or self-medication, which is defined as the process of actions or decisions an individual takes to minimise stress, anxiety, unhealthy behaviours or symptoms experienced by illness, usually through the process of taking drugs, natural medicines or home-remedies, through one's own initiative, or through the advice from others, without consulting professional healthcare services (Riegel, Dunbar, Fitzsimons, Freedland, Lee, Middleton, Stormberg, Vellone, Webber & Jaarsma, 2017:2; Bennadi, 2013:19). Furthermore, it can also be seen as the active desire of individuals to want to be intelligent and well-informed regarding the prevention, diagnosis and treatment plans, forming part of disease management (Bennadi, 2013:19). Bennadi (2013:20) further reported that in Punjab, India 73% of the population engaged in self-medication, this was especially prevalent if individuals were well-educated.

In a study by Webair and Bin-Gouth (2013:1135) conducted in Yemen, it was found that for an individual to seek formal healthcare, they need to categorise the perceived illness as severe. In cases where individuals perceive their illness as mild or moderate in severity, they are less likely to seek formal healthcare and more likely to use alternative healthcare, traditional healers or to self-medicate (Webair & Bin-Gouth, 2013:1135). This occurs due to the fact that individuals are more likely to use what is easily or readily available to them. However, if they perceive the illness as severe, they are more willing to put in extra effort to treat their symptoms (Webair & Bin-Gouth, 2013:1136).

In contrast to this, a study conducted in Kenya by Abubakar, Van Baar, Fischer, Bomu, Gona and Newton (2013:3), found that individuals who perceived themselves as ill, would rather seek formal medical care or use medications prescribed by a pharmacist, before they would engage in prayer or visit a traditional healer. This was especially true in the case of mothers with ill children; however, it was found that if formal healthcare failed to cure their child in a timeous manner, mothers would seek alternative healthcare (Abubakar et al., 2013:4).

2.3.3.2. Socio-cultural factors influencing health-seeking behaviour

In a study by Mahmood et al. (2009:73), women were found to be ill more often than men but sought health care services less often than men. Similar results were found in a study conducted in Bangladesh by Amin, Shah and Becker (2010:8). However, a study conducted by Abaerei (2016:24) in Johannesburg, found that women were more likely to access health care than their

male counterparts. These findings may be linked to the interaction of gender and cultural beliefs in a given community.

Furthermore, similar results were found regarding the influence of socio-cultural factors influencing the health-seeking behaviours of children. This is due to the fact that women are the caregivers in family systems but still abide by their husband's decisions, leaving children to wait longer before treatment (Abaerei, 2016:5). In a study by Webair and Bin-Gouth (2013:1134) conducted in Yemen, it was found that health-seeking decisions regarding children were most frequently decided by mothers. The study found that low decision-making power of women, due to cultural norms, caused a delay in appropriate health-seeking behaviours for their children's illnesses (Webair & Bin-Gouth, 2013:1134). This delay was found to be linked to the high number of child deaths in developing countries (Webair & Bin-Gouth, 2013:1134). A study by Abubakar et al. (2013:5) in Kenya, found contrasting results, namely that fathers were more likely to be consulted regarding health-seeking decisions, as they were the breadwinners and thus, the authority figure in the family.

The study by Webair and Bin-Gouth (2013:1135), found that certain cultural beliefs may influence health-seeking behaviour. It was found that if individuals perceive an illness to have been derived from non-medical causes, these individuals are more likely to consult traditional healers for spiritual cleansing, than to seek formal health care (Webair & Bin-Gouth, 2013:1135). In some cases, individuals will eventually seek out formal healthcare, however this is often delayed until illnesses are perceived as severe, which can cause severe health complications (Abubakar et al., 2013:1). A study by Abubakar et al. (2013:4), conducted in Kenya, found that if individuals believed that the illness derived from biological mechanisms, they would seek formal healthcare services. However, if illnesses were believed to be a form of mental illness, then traditional healers or spiritual elders were more likely to be consulted (Abubakar et al., 2013:4).

It was further found that due to cultural beliefs about the origin of illness, preventative health measures are taken. These measures usually include a traditional healer and rituals, and do not involve the formal healthcare sector (Abubakar et al., 2013:4). This was especially apparent when elders in the community advised the assistance of traditional healers, even if the individual disagreed with the elder, they would still seek traditional healing to show respect to the elders of the community (Abubakar et al., 2013:4-5).

The study that Abaerei (2016:3) conducted in Johannesburg indicated that race could be a further factor influencing health-seeking behaviour. This study found that white persons were more likely

to seek treatment than black persons. This aspect may be linked to past discrimination between races. In communities with high racial and ethnic discrimination there is often inequality regarding access to services and large income disparities between races, thus, certain races will be less likely to have access to and to utilise good quality healthcare (Braveman, Egerter & Williams, 2010:385).

A study by Abubakar et al. (2013:5), conducted in Kenya, found that younger generations who have adapted to the modern world, are less likely to use traditional healers and more likely to use formal healthcare services. This is due to a belief that traditional healers no longer have relevance in their cultural and spiritual beliefs (Abubakar et al., 2013:5). Similar results were found in a study by Musoke et al. (2014:1051) in Uganda, where participants indicated infrequent use of traditional healers, however Musoke et al. (2014:1051) questions whether the use of a traditional healer is under-reported due to stigma in the community related to traditional medicine.

Lastly, individuals who exhibit high levels of social engagement and trust, find value within their community. Thus, they are more likely to have positive health behaviours, which in turn reduces health complications and increases their quality of life (Bircher & Kuruvilla, 2014:373).

2.3.3.3. Socio-economic factors influencing health-seeking behaviour

Studies conducted in Sub-Saharan Africa, have indicated that a lack of education, the status of being an immigrant and the factor of living in poverty, has contributed to individuals utilising health-care services less often than non-vulnerable groups (Abaerei, 2016:3). Furthermore, a study conducted by Webair and Bin-Gouth (2013:1136) conducted in Yemen, found that health-seeking behaviour regarding formal healthcare is more likely to occur with educated mothers than with uneducated mothers, as such, children in areas with low maternal education are more likely to experience health complications. As such, an increase in education has been found to increase health-seeking behaviours (Abaerei, 2016:3).

School education levels are important regarding health-seeking behaviour, as individuals are more likely to understand biological aspects and be introduced to health promotion in school curriculums (Braveman et al., 2010:386; Webair & Bin-Gouth, 2013:1136). Furthermore, educated individuals are more likely to understand media campaigns designed to promote healthy behaviour (Webair & Bin-Gouth, 2013:1136). Similar results were found in Bangladesh, where a study conducted by Amin et al. (2010:8) found that more educated women were able to understand media campaigns, thus having more understanding regarding the severity of symptoms and illnesses. Lastly, individuals with higher education levels are more likely to be

employed in positions that provide health benefits, thus they are more likely to use these benefits (Braveman et al., 2010:386).

Mahmood et al. (2009:73) found that in developing countries, such as Bangladesh, the health-seeking behaviour of the poor is limited to affordability of health services. Expenditures of transport, medication and consultation may act as a deterrent for individuals when seeking healthcare in developing countries (Mahmood et al., 2009:73; Webair & Bin-Gouth, 2013:1136). The study by Mahmood et al., (2009:73) conducted in Bangladesh, further found that health-seeking behaviour was deterred by a lack of funds and limited accessibility to healthcare services. Similar results were found in a study conducted by Musoke et al. (2014:1050) conducted in Uganda and a study by Amin et al. (2010:7) in Bangladesh, which found that individuals living in rural communities, were less likely to utilise formal healthcare systems, especially if access to formal healthcare was poor due to distance, infrastructure or lack of resources. Thus, individuals who live in communities that have large disparities in individual incomes, high levels of poverty and poor living conditions, are less likely to seek and receive high quality healthcare (Bircher & Kuruvilla, 2014:374).

2.3.3.4. Political and structural factors influencing health-seeking behaviour

Health-seeking behaviour is not only affected by internal or community factors but is also affected by a country's health system (Grundy & Annear, 2010:10). As such, the operations of a health care facility and the attitude of healthcare providers is likely to influence the perceptions and beliefs of individuals regarding health-seeking behaviour (Grundy & Annear, 2010:10). An example of this can be seen in Abaerie's (2016:5) Johannesburg study, that found when an individual experiences dissatisfaction with healthcare services, especially those provided by the government, they are more likely to be discouraged from seeking formal health treatments (Abaerie, 2016:5).

In a study by Webair and Bin-Gouth (2013:1134) conducted in Yemen, it was found that countries with several health-seeking practices, such as formal, traditional and alternative practices; and a lack of knowledge regarding what constitutes as a serious illness, leads to delays in health-seeking behaviour, which has life-threatening consequences (Webair & Bin-Gouth, 2013:1134; Abubakar et al., 2013:1).

A further factor leading to a delay in health-seeking behaviour is inadequate, under-resourced and under-staffed medical facilities. In these cases, individuals are less likely to seek formal healthcare, especially if their symptoms are perceived as mild to moderate (Abubakar et al.,

2013:1; Braveman et al., 2010:358). Similar results were found in a study conducted by Musoke et al. (2014:1050) in Uganda, which found that individuals who are unable to access formal healthcare services easily and are unlikely to utilise these services, leading to poorer health in rural communities.

2.3.3.5. Spiritual factors

As spirituality influences life decisions, actions and personality, it is expected that spirituality will be a factor of health-seeking behaviour (Mishra, Togneri, Tripathi & Trikamji, 2017:1283). This is seen in several studies that have found that spirituality can influence both health and health-seeking behaviour as it plays a role in health promotion and disease prevention (Mishra et al., 2017:1296). A study conducted by Hilbers, Haynes and Kivikko (2010:5) in Australia, found that 80% of respondents stated that spirituality impacted their health-seeking behaviour and healing. Respondents attributed this to the fact that spirituality provides support, it increases positivity, it provides a framework of how to live a healthy lifestyle and avoid risky behaviour and it can be seen as a divine punishment for sin (Hilbers et al., 2010:6). Furthermore, spirituality can influence mental health as it provides coping mechanisms and reduces the likelihood that stress will result in severe emotional disturbances resulting in disorders (Koenig, 2012:7). This is due to the fact that spiritual beliefs are able to give meaning or purpose to events and the belief that a powerful being will provide for personal needs (Koenig, 2012:7).

Spirituality has the ability to positively influence health and health-seeking behaviours due to rules and regulations that govern spirituality. Most spiritual belief systems advocate against smoking, drugs, excessive alcohol, risky sexual behaviour or stressful life events such as divorce, thus highly spiritual individuals are more likely to live healthy lifestyles (Koenig, 2012:7). A review by Koenig (2012:8-9) of previous studies found that over 100 studies indicated that individuals with higher spirituality are less likely to smoke cigarettes and over 20 studies indicated that highly spiritual individuals are more likely to partake in moderate exercise and healthier diets. Lastly, in over 90 studies, individuals who were highly spiritual were found to be less likely to engage in risky sexual behaviour, thus decreasing the risk of sexually transmitted infections (STI's).

A study conducted in Ghana by Kretchy, Owusu-Daaku and Danquah (2013:5) found that spirituality can influence health-seeking behaviour negatively. Results indicated that individuals with high spiritual beliefs were less likely to adhere to treatment methods. A possible reason provided by Kretchy et al. (2013:6) was that highly spiritual individuals were more likely to experience peace and place trust in divine healing than traditional medication. This often led to

individuals purposefully stopping treatment methods in preparation for divine healing. For example, a study conducted in Pakistan by Anwar, Green, Norris and Bukhari (2015:292) found that in the Muslim belief the Quran holds 'Verses of cure' used for treating illnesses, although individuals are not discouraged from seeking formal healthcare, the belief remains that Allah is the divine entity that will provide the cure (Anwar et al., 2015:292).

As can be seen above, various studies have indicated how spirituality is a factor of health, however, there are minimal studies regarding spirituality as a factor of health-seeking behaviour, thus indicating a gap for possible further research in both a national and international context. As will be discussed in the subsequent sections, studies regarding Charismatic Christianity and the effects on health-seeking behaviour, have been conducted on an international scale but research remains scarce for the South African context.

2.4. OVERVIEW OF CHARISMATIC CHRISTIANITY

Charismatic Christianity is a form of Christianity that was established in the 1700's (Asamoah, 2016:1642). It is the goal of the research study to gain an understanding of whether Charismatic Christianity has an influence on its follower's health-seeking behaviour. Before it is possible to investigate the link between religion and health-seeking behaviour, it is necessary to define Charismatic Christianity as well as, to have an understanding of its development. Furthermore, the core beliefs of Charismatic Christianity will be discussed, including the perceptions held about health and health-seeking. Lastly, the health-seeking behaviour of Charismatic Christianity, derived from previous research will be discussed.

2.4.1. Defining Charismatic Christianity

Charismatic Christianity, also known as Pentecostalism, is a religion based on Christian faith and the belief in the trinity (God, Jesus and the Holy Spirit) by accepting the Bible as the word of God, the belief that Jesus Christ is saviour and by placing emphasis on the importance of the Holy Spirit (Dein & Cook, 2015:98). As such, Charismatic Christianity involves an emphasis on the workings of the Holy Spirit on both a conscious and theoretical level (Anderson, 2013:1). Charismatic Christianity places emphasis on miracles and signs derived from the emotional, spiritual and supernatural realms, especially in the context of speaking in tongues (glossolalia), faith healings and exorcisms (Encyclopedia of Religion, 2019). It is important to note that these encounters are a personal and subjective experience, thus they will differ for every person. The only commonality is in the fact that an individual is filled with the presence of the Holy Spirit (Encyclopedia of Religion, 2019).

One the reasons for the success and growth of Charismatic Christianity on a global scale, is because the religion is seen to be adaptable and flexible. Thus, it has been able to grow and adapt to changes in modern times and in various cultural groups (Anderson, 2013:4). However, due to its adaptability, Charismatic Christianity is often easily influenced by its surroundings, leading to splinter groups or new religions (Anderson, 2013:4).

2.4.2. The development of Charismatic Christianity

Charismatic churches are one of the fastest growing churches in Christianity in the modern world. Charismatic Christianity is difficult to define, as many aspects are involved, as such it is estimated that between 250 million to 500 million individuals identify as Charismatic Christians (Anderson, 2013:1; Synan, 2011:7).

Charismaticism was established through the use of evangelical foundations through protestant movements in the 1700's (Asamoah, 2016:1642). One such protestant movement was called the Holiness Movement, also known as the Charismatic Renewal, which began when a prominent member of the Protestant Church, Dennis Bennett, experienced the power of the Holy Spirit and began to talk in tongues (Synan, 2011:8; Stetzer, 2013). This movement taught that the Bible's teachings should be seen as literal and not figurative. It further emphasised personal experiences and conversations through prayer and encouraged members to strive for moral perfection through their actions with the promise of achieving eternal life (Anderson, 2013:2).

As the popularity of the Charismatic Renewal Movement grew on a global scale, more churches began to develop outside of the Protestant and Evangelical Churches and were seen as Independent Charismatic Churches (Stetzer, 2013). Although Charismatic Christianity initially developed in western communities, independent Churches in Africa, Latin America and Asia can also identify as and prescribe to Charismatic Christianity (Anderson, 2013:1).

2.4.3. Core beliefs of Charismatic Christianity

The core beliefs of Charismatic Christianity are founded in the book of Acts and through the history of the Pentecostal Church. These beliefs involve glossolalia (speaking in tongues); healing and miracles; the power of personal testimony, spiritual growth; and prophecy (Asamoah, 2016:1643; Encyclopedia of Religion, 2019). It is also the role of Charismatic Christians to spread the gospel through the empowerment of the Holy Spirit (Asamoah, 2016:1642).

In the past, these core beliefs were expressed in church services through the acts of glossolalia or praying out loud, prophesy giving, healing of the sick, exorcisms, singing and dancing (usually

during praise and worship). Services appeared uncoordinated to individuals who were not members, as running, jumping, crying and shouting were encouraged (Encyclopedia of Religion, 2019). However, in modern times more structure has been created in sermons and the above only occur in controlled circumstances, however, in non-western cultures, these rituals are still practiced (Encyclopedia of Religion, 2019).

2.4.4. Health beliefs of Charismatic Christianity

Charismatic Christianity emphasises the term divine healing. This implies that it is God's love and not an impersonal spiritual force that leads to healing (Brown, 2011:4). Of the above-mentioned core beliefs, divine healing is seen to be one of the most important aspects of Charismatic Christianity and includes physical and spiritual healing, deliverance, miracle and in extreme cases exorcisms (Brown, 2011:4). Charismatic Christians have two approaches to healing, deliverance and miracles (Asamoah, 2016:1646).

Deliverance is a form of healing that is practiced by some Charismatic Christians. Those who believe in deliverance, state that all illnesses or life challenges are due to the interference of demons in an individual's life, or they are servants to Satan (Mercer, 2013:598). In these cases, only after expulsion of these demons will the suffering end, therefore allopathic medicine will not be able to cure illnesses (Asamoah, 2016:1646; Mercer, 2013:598). It is important to note that suffering can be in the form of mental or physical illness (Asamoah, 2016:1646). The belief further emphasises that the type of illness experienced will be directly related to the type of demon involved in the possession (Mercer, 2013:598). As such, individuals who are believers of deliverance do not attribute illness to biological, medical or environmental factors but rather an attack from the supernatural realm (Asamoah, 2016:1646; Mercer, 2013:598).

The second form of healing involves the event of a miracle. Those who believe in miracles have a belief in Godly love, it is believed that those who have faith in God and live as holy a life as possible, will be gifted with a miracle in the case of illness (Cartledge, 2013:519). Miracles ensure the healing process through prayer which can be done by various role players, including: the family members of the ill individual, prayer partners and the church leaders (Cartledge, 2013:519). Individuals who believe in miracles are willing to agree that illnesses can derive from a biological or environmental nature, however, they believe that the power and love of God is able to cure all illnesses, therefore allopathic medicine is not necessary (Cartledge, 2013:519).

2.4.5. Health-seeking behaviour of Charismatic Christians

There appears to be little research conducted into the health-seeking behaviours of Charismatic Christians, thus indicating a gap for the research study. Despite this, a study in Belgium found that religion or spirituality, in general, can influence how a patient perceives an illness, thus religion has the ability to enhance or damage the quality of life for individuals with chronic illnesses (Arrey, Bilsen, Lacor & Deschepper, 2016:2). Individuals who believe that they have been abandoned by their God will be impacted negatively, while individuals who still experience God's love and grace will be impacted positively. As such, when working with an ill individual it is important to understand how they are personally affected by religion (Arrey et al., 2016:4).

A study conducted in Malawi indicated that faith healing was prominent in Charismatic Christian communities, however, this did not mean that the religious leaders were against encouraging the use of allopathic medicine, especially in the case of HIV (Manglos & Trinitapoli, 2011:113). However, these leaders were found to discourage preventative methods, such as condom usage, possibly due to the fact that they did not want to encourage sex before marriage (Manglos & Trinitapoli, 2011:113). This is an important factor in health-seeking behaviour, as it has been found that individuals with mental illnesses are more likely to consult their religious leaders than healthcare professionals (Leavey, Dura-Vila & King, 2012:351). In Zimbabwe it was also found that individuals were converted to Charismatic Christianity through the promise of healing in regard to physical illnesses, as such prophets were conducting healing practices and individuals were not utilising allopathic medicine practices (Togarasei, 2015:60).

Studies found that for individuals experiencing mental health illnesses, religious leaders would be contacted prior to a professional in the mental health industry, in some cases professionals would never be consulted (Leavey et al., 2012:352). These religious leaders provide guidance, healing and reconciliation to community members; however, these religious leaders are often not trained in mental health can cause further psychological distress (Leavey et al., 2012:352). This was especially in cases, where the origin of the mental illness was believed to be spiritual in nature, such as the individual being under attack by demons or under the control of Satan (Asamoah, 2016:1646; Mercer, 2013:598).

Religion provides individuals with meaning, action and resilience to cope with suffering, thus it is expected to influence health-seeking behaviours (Leavey et al., 2012:354). The beliefs of Charismatic Christians will have a direct influence on their health-seeking behaviour. As a result, social work practice in the healthcare system will benefit from understanding the core beliefs and

religious practices regarding health. Social workers in the field would require this knowledge to provide services that are spiritually sensitive, non-judgmental and diverse to better meet the needs and understand the behaviours of Charismatic Christians.

2.5. THE ROLE OF THE SOCIAL WORKER

Social workers who practice within the healthcare domain often work within a multi-disciplinary team (MDT). The MDT consists of various healthcare disciplines that interact and work together on one patient for the purpose of providing holistic care for the patient (Jalil, Lamb, Russ, Sevdalis & Green, 2012:1). Social workers perform various roles in healthcare settings and are involved in preventative care, primary care, secondary care, tertiary care and restorative care (Kirst-Ashman, 2013:371-372). Preventative and primary care is conducted prior to diagnosis or onset of illness, secondary care occurs after diagnosis, tertiary care is implemented during the treatment of severe or life-threatening illnesses and restorative care occurs during the treatment and rehabilitation phase to ensure a recovery (Kirst-Ashman, 2013:371-372). They are further involved in providing individual, couple, group and family counselling, crisis intervention, patient/family education, resource referral and advocacy (National association of social workers, 2011).

The first role of the social worker is psycho-social assessment which screens for risks, support systems, needs and strengths, this is in conjunction with the role of consultation, whereby social workers provide expertise within the multi-disciplinary team (National association of social workers, 2011:1). One aspect that is important to discuss is the assessment of religion and spirituality. It is imperative that social workers in healthcare have a knowledge of all religions, as spirituality is often used as a source of strength for individuals, it further provides comfort, consolation and guidance, therefore it can be utilised as a tool for empowerment (Kirst-Ashman, 2013:91). Furthermore, an understanding of religion is important as it forms part of an individual's identity and contains certain rituals or rites that may be necessary for an individual to participate in during the healing process (Kirst-Ashman, 2013:91). In a study in Australia, conducted by Hilbers et al. (2010:6), it was found that over 70% of individuals wanted a team member to ask about their spirituality. They believed that this would facilitate a healthy relationship between medical staff and patients. In contrast to this 10% of respondents indicated that staff should not enquire about their spirituality, however, some respondents further added that they would share if staff were able to remain non-judgmental and culturally sensitive or if they were severely ill (Hilbers et al., 2010:6). As social workers have a unique role of advocating for the rights and needs of individuals and a professional standing in the multi-disciplinary team, they are afforded

the opportunity to communicate the spiritual needs of individuals to the multi-disciplinary team (Craig & Muskat, 2013:11).

Secondly, social workers can provide counselling appropriate to meet the bio-psychosocial needs of clients. They provide emotional support to individuals and families during diagnosis, treatment and end-of-life care; thus, it is important that social workers have an understanding of medical jargon, terminology and illnesses (Kirst-Ashman, 2013:372). Furthermore, social workers in the healthcare setting must use emphatic communication to perceive accurately and sensitively what the client system feels and understands (Grobler et al., 2013:53). As such, the social worker must remain culturally sensitive, non-judgmental and avoid placing their own beliefs on the client, as clients should be awarded the right to express self-determination and be involved in decision making (Ferreira & Ferreira, 2015:503). Social workers can assist in helping terminally ill patients with planning and organising of important tasks or end-of-life wishes (Kirst-Ashman, 2013:372).

Thirdly, social workers can provide education services to patients and their families to facilitate understanding of hospital processes; increase understanding of illness/disability on relationships; and facilitate life transitions when health conditions require a modified lifestyle (National association of social workers, 2011:1). Education regarding illnesses post diagnosis, is a further role in order to ensure that patients understand the treatment, diagnosis, prognosis and necessary adjustments to lifestyle. This is usually done in conjunction with the multi-disciplinary team (Kirst-Ashman, 2013:372). Furthermore, social workers are involved in preventing illness through discouraging risky behavior, educating and advocating for healthy lifestyles (Kirst-Ashman, 2013:372).

Lastly, social workers have a role in the planning of patient discharge, this is especially important when clients need to be referred to other services or need alternative placement or care (National association of social workers, 2011:1). Furthermore, social workers can assist in rehabilitation and discharge to assist patients in returning home, accommodating their new conditions and by providing links to resources in their community (Kirst-Ashman, 2013:372).

2.6 SUMMARY

The literature review provided an in-depth overview, from both an international and national perspective, regarding health, healthcare and the current health status and trends in South Africa, as well as the general factors that influence health-seeking behaviour. Furthermore, the literature review discussed Charismatic Christianity in terms of its core beliefs and more specifically, it's

beliefs and practices regarding health and health-seeking. The literature review pinpointed gaps within the research regarding the spiritual factors that influence the health-seeking behaviours of Charismatic Christians.

In the following chapter, chapter three, Research methodology and empirical study, a detailed description of the research methodology used in the study will be provided. Furthermore, the findings of the study will be discussed and supported by verbatim quotes from participants, as well as, by research provided in the literature review of chapter two.

Chapter three focusses on the research methodology and empirical findings.

CHAPTER THREE

RESEARCH METHODOLOGY AND EMPIRICAL STUDY

3.1. INTRODUCTION

This chapter includes a detailed description of the research methodology utilised in this study, as well as the presentation of the research findings. In the first section, the research methodology includes the research approach, type of research and the research design utilised. Furthermore, the research methods include the research population, the sampling method, data collection and data analysis methods, data quality and the pilot study. Lastly, the ethical considerations considered in the study are provided. In the second half of the chapter, the research findings are presented and discussed using a thematic analysis.

The research was guided using a qualitative approach in order to reach the aim and objectives of the study. The aim of this study was:

To explore the spiritual factors influencing health-seeking behaviours of the Charismatic Christians in Johannesburg, Gauteng.

The objectives were as follows:

- To conceptualise and contextualise spiritual factors influencing health-seeking behaviour from a health belief perspective.
- To explore and describe the spiritual factors influencing health-seeking behaviour of Charismatic Christians in Johannesburg.
- To make suggestions to improve social work services in healthcare, taking into consideration the factors influencing health-seeking behaviour among Charismatic Christians in Johannesburg

The empirical study was guided by the following question: **What are the spiritual factors influencing health-seeking behaviours of Charismatic Christians in Johannesburg, Gauteng.**

3.2. RESEARCH APPROACH

The research paradigm utilised for the study was interpretivism. Interpretivism strives for empathic understanding of the participants lived experiences within their particular historical setting (Neuman, 2014:103). Interpretivism argues that all people are functioning through a process in which they attempt to create understanding about the world in which they live. This understanding is achieved through giving meaning to, defining, interpreting and justifying everyday actions (De Vos, Strydom, Schulze & Patel, 2011:8). Due to interpretivism's relation to hermeneutics, empathic understanding was gained through detailed examinations of participants experiences that provided subjective, in-depth understanding (De Vos et al., 2011:8). This helped achieve understanding regarding the factors influencing Charismatic Christians health-seeking behaviour, as their personal realities were explored, explained and interpreted.

The research paradigm informed the research approach, the approach utilised was the qualitative approach. The qualitative approach is usually applied to natural settings and it attempts to explain and interpret phenomena and the meanings that individuals associate with it, through rich, detailed descriptions (Lietz & Zayas, 2010:189). Rich descriptions were achieved through linguistic methods of data collection, from a variety of sources (Nieuwenhuis, 2016a:53). The use of a qualitative approach allowed the study to explore and describe the spiritual factors influencing Charismatic Christians health-seeking behaviour (Nieuwenhuis, 2016a:53).

The primary research purpose was exploratory, in order to gain insight into the spiritual factors of Charismatic Christianity that influence health-seeking behaviour as there was a lack of knowledge in this area of research within a South African context (Padgett, 2017:16). The secondary purpose was descriptive with the aim of obtaining rich descriptions about how the spiritual factors of Charismatic Christians influence health-seeking behaviour (Neuman, 2014:38).

3.3. TYPE OF RESEARCH

The research approach consisted of applied research, this was necessary as this type of research provided data on health-seeking behaviours that could be used to improve services of social work in health-care settings (Jansen, 2016:9). The data gathered can help social workers understand the spiritual factors that influence health-seeking behaviour. With this knowledge social workers will be aware of and be able to improve health-seeking behaviours of Charismatic Christians in a spiritually sensitive manner. Applied research ensured that the concern of those who do not engage in health-seeking behaviour will be understood and improved (Neuman, 2014:27). This

study was short term, done on a small scale to ensure that practical results could be provided in a relatively short time-frame (Neuman, 2014:27).

3.4. RESEARCH DESIGN

The design used was the case study design, examining the case as a system investigating both the internal experiences and the environment of participants (Neuman, 2014:42). The study was in depth and descriptive, using a data rich source from several participants to ensure that the research goal was obtained (Nieuwenhuis, 2016b:83). This design ensured that the purposes of exploring and describing the spiritual factors that influence health-seeking behaviour were met (Nieuwenhuis, 2016b:82). The case study was conducted with individuals and obtained the necessary data about the phenomenon (Neuman, 2014:42). The instrumental case study design was specifically used, as it ensured that the contemporary phenomenon of health-seeking behaviour was explored in the bounded context of Charismatic Christianity (Nieuwenhuis, 2016b:81; Fouché & Schurink, 2011:321). By using the instrumental case study design, insight was gained into the phenomenon of health-seeking behaviour which could be used to create recommendations to facilitate practice and refine theory to increase health-seeking behaviour (Nieuwenhuis, 2016b:82-83). Thus, several cases were investigated to ensure that accurate comparisons and distinctions could be made between cases (Fouché & Schurink, 2011:322). This ensured that specific knowledge was gained regarding the health-seeking behaviour of Charismatic Christians in Johannesburg, as the research was grounded in real experience (Fouché & Schurink, 2011:321).

The advantages of using the instrumental case study design were that in-depth detailed descriptions of the spiritual factors influencing health-seeking behaviour could be gained, which ensured a better understanding of the phenomena, in conjunction with this, insight into the phenomena was gained which can help refine theory and practice (Nieuwenhuis, 2016b:82; (Fouché & Schurink, 2011:321). By using in-depth descriptions, the case study design ensured that more comprehensive evidence regarding the spiritual factors of Charismatic Christians influencing health-seeking behaviour were obtained (Neuman, 2014:42).

3.5. RESEARCH METHODS

Research methods discussed include the study population and sampling, data collection and data analysis methods, data quality and the implementation of the pilot study.

3.5.1. Study population and sampling

The research population included all South African citizens living in Johannesburg, Gauteng province who were characterised as Charismatic Christians due to their beliefs and religious affiliation within the year 2020. The study population for this study was adult Charismatic Christians residing in Johannesburg, Gauteng during the period of 2020 (Strydom, 2011a:223). The New Creation Family church situated at the King's School, Robinhills, Gemsbok Road, Randburg, was chosen as the church to draw the sample from, as it is a well frequented church in the Johannesburg area, with diverse demographics in terms of race, age, education level and socio-economic background.

Non-probability sampling was utilised, as the odds of selecting a particular Charismatic Christian, residing in Johannesburg was unknown (Strydom & Delport, 2011:391). The specific type of sampling which was utilised was volunteer sampling, where the sample was selected from participants who were both willing to participate and who met the purposive sampling requirements needed to participate in the research study (Murairwa, 2015:186). This method was used as it ensured voluntary participation and it allowed limited contact with the researcher, adhering to Covid-19 protocols. Volunteer sampling is defined as participants who willingly choose to participate in the study, usually occurring after the use of purposive sampling, where a potential group of participants are chosen due to the fact that they possess certain characteristics that are necessary to participate in the study (Murairwa, 2015:186).

The participants were recruited, by the researcher firstly approaching the pastor of the New Creation Family church for permission to conduct the research. As no in-person church services were held due to Covid-19, information regarding the research was posted on WhatsApp church groups. Those who were interested could contact the researcher through the contact details provided. The researcher then explained the study to them telephonically, after they had reacted to the information regarding the research, posted on WhatsApp church groups. This was followed by purposive sampling, by selecting from these volunteers, those who met the selection criteria.

Purposive sampling entails choosing participants due to the fact that they possess specific characteristics that are relevant to the study (Strydom & Delport, 2011:391). As such, participants for this study were chosen due to possessing the specific characteristics of religious affiliation to Charismatic Christianity, namely a Charismatic Christian Church, namely, New Creation Family Church. This was to ensure a sample that met the inclusion criteria.

The sample for the study had to meet the following inclusion criteria:

- Resident in Johannesburg Metropolitan Area during the period of 2020.
- Classified as an adult, being over the age of eighteen.
- Male or female
- Single, married, divorced or widowed
- Characterise themselves as being Charismatic Christians
- Attend the New Creation Family Church, Randburg.
- Must have sought health care services in the past five years.

If participants who met the criteria were interested in participating, they were provided with an informed consent form via email, to read through and sign if interested. Participants were also provided with the researcher's cell phone number, in the event that they wanted further clarification regarding the research process. Once the potential participants had signed the informed consent form, and returned it via email to the researcher, an interview was arranged with each participant. Interviews were conducted with ten participants, two of these having been included from the pilot study, at Oasis Haven (a ministry of the church), in a therapy room, until the point of data saturation, which ensured in-depth and descriptive results that were able to meet the goals and objectives of the study.

3.5.2. Data collection

The method of data collection that was utilised was one-on-one interviews, which was in accordance with the qualitative approach. The purpose of using one-on-one interviews as a method of data collection was to collect data from the individual participants to learn about their opinions, beliefs, viewpoints and behaviours, through a direct exchange between the participant and researcher (Nieuwenhuis, 2016b:92; Greeff, 2011:342). Nieuwenhuis (2016b:92) confirms that the interview was aimed at obtaining rich, descriptive data which was used to explore and describe the phenomena. This was a suitable data collection method to help understand what and how spiritual factors of Charismatic Christianity influences health-seeking behaviour (Nieuwenhuis, 2016b:92; Greeff, 2011:342).

The specific type of interview which was utilised was the semi-structured one-on-one interview, which was utilised with the purpose of exploring the known phenomena to gain detailed and in-depth descriptions (Greeff, 2011:352). The researcher predetermined a set of questions to explore the spiritual factors that influence health-seeking behaviour, but the interview was guided by what the participant chose to share, the researcher then further engaged in probing and clarification to explore these factors (Nieuwenhuis, 2016b:93). The interview schedule was

developed by the researcher after an in-depth, extensive literature review, a copy of the interview schedule is attached as Appendix 4. The developed interview schedule consisted of questions directly related to the exploration and description of the spiritual factors of Charismatic Christians that influence health-seeking behaviour (Nieuwenhuis, 2016b:93).

The semi-structured interview was conducted individually with participants and was voice recorded with their permission for data collection purposes. Interviews were conducted once with each participant, however, participants were informed that the interview process may be extended if data saturation was not reached. Participants were informed that a second interview would only be conducted if more information was needed, however this was not necessary as data saturation was reached with the first interview of each participant (Greeff, 2011:352). During the first interviews participants provided data that was informative, comprehensive and inclusive of many factors affecting the health-seeking behaviours of Charismatic Christians, as such it was believed that data saturation was achieved. The interviews were not conducted at New Creation Family Church, but rather in the therapy room of Oasis Haven (a ministry of the church), as this venue provided privacy and comfort for one-on-one interviews.

In order to adhere to Covid-19 protocols, all interviews were only conducted once small gatherings were no longer prohibited. Furthermore, in line with these protocols, interviews were conducted after health screening in a well-ventilated room with strict adherence to mask wearing and sanitiser was provided and used during sessions. Lastly, the interviewer and participants sat 1.5 meters apart and there was no sharing of stationary as consent forms had been emailed to limit the risk of possible transference of the Covid-19 virus.

The advantages of using a semi-structured one-on-one interviews was that substantial amounts of narrative data, that were detailed and descriptive, could be gathered in a relatively short period which was necessary to explore and describe the spiritual factors of Charismatic Christians that influence health-seeking behaviour (Greeff, 2011:360). Although this was advantageous, the design posed several disadvantages including, participants who were dishonest, participants who were unwilling to share certain aspects or were not willing to discuss the phenomena in detail. This may have been further intensified due to the use of an audio recording, which may have influenced the participants' emotions, behaviour and willingness to participate (Greeff, 2011:360). The above challenges were lessened by building rapport with participants in order to help them feel safe, welcome and more willing to share and explore their thoughts and feelings (Grobler et al., 2013:12). This was done by creating a safe environment through the use of a private,

comfortable room, as well as, by the researcher maintaining a non-judgemental, accepting attitude towards the participant (Grobler et al., 2013:13).

3.5.3. Data analysis

A thematic data analysis was employed in this study. This ensured that the researcher could identify, analyse and report patterns from the data regarding the spiritual factors that influence health-seeking behaviour (Vaismoradi, 2013:400). The thematic analysis further ensured that the data gathered through the semi-structured interviews was detailed and descriptive to ensure the research purposes of exploring and describing the spiritual factors that influence health-seeking behaviour were obtained (Braun & Clarke, 2012:58). The researcher reported on the experiences, meanings and realities of the participants through a thematic analysis of the semi-structured interviews, this was influenced by the theoretical framework, namely the social learning theory and the health belief model (Clarke & Braun, 2013:120-123; Braun & Clarke, 2012:57). Several researchers have developed their own phases of thematic analysis, but for the purposes of this study the process of Braun and Clarke was utilised.

3.5.3.1. Six phases of thematic analysis

The six phases of Clarke & Braun, (2013:120-123) and Braun & Clarke, (2012: 60-69) are subsequently described:

- **Familiarisation with the data:** In order to ensure the researcher is familiar with the data, thus facilitating the data analysis process, the researcher needs in-depth knowledge and understanding of the collected data (Clarke, Braun & Hayfield, 2015:230). This was achieved by the researcher, as the researcher become intimately familar with the data received from the semi-structured interviews. This was achieved by initially listening to each audio-recording, thereafter the data was transcribed verbatim and the researcher read the transcipts serveral times to become familiar with the data. During this process all initial analytical observations were made and recorded.
- **Coding:** Coding entails identifying and labeling similar patterns that are apparent in the available data (Clarke et al., 2015:230). During this phase the researcher generated labels for important components of the data, which had relevance to the spiritual factors of Charismatic Christianity that affect health-seeking behaviour. These codes were used to guide further analysis by providing codes for every data item, followed by collating all the codes with their relevant data extracts.

- **Searching for themes:** Once patterns are identified and coded it is necessary to group similar patterns into themes which will be used for further data analysis (Clarke et al., 2015:230).The researcher did this by reviewing the coded data and further analysing it to identify all similarities in the data set. The researcher then constructed themes from these similarities which were organised by collating all the coded data relevant to each theme.
- **Reviewing themes:** The purpose of reviewing themes was to ensure there was a central concept for each theme, as such, adjustment of themes is sometimes necessary (Clarke et al., 2015:230). This phase involved the researcher reviewing the collated themes to ensure that the themes were relevant in terms of both the coded extracts and the full data set. In some cases it was necessary to combine themes, expand on themes or discard themes in their entirety if they were not relevant to the coded data or full data set.
- **Defining and naming themes:** In order to ensure clarity regarding themes it is necessary to provide a definition for each theme and a clear name (Clarke et al., 2015:230). During this phase the researcher conducted and wrote a detailed analysis of each theme. Defined themes were created to be clear, specific and unique to avoid confusion or uncertainty. Once each theme was defined accurately and an appropriate name was provided for the theme that encompassed its meaning in an accurate and enticing way.
- **Producing the report:** Written reports are done with the purpose of creating a narrative from data extracts, from which themes can be clearly seen and conclusions can be drawn (Clarke et al., 2015:230). Writing-up involved weaving together the analytic narrative and the data extracts to achieve a report that was clear, concise and coherent, yet remaining persuasive, compelling and descriptive, while contextualising it in relation to existing literature.

3.5.4. Data Quality

The data quality was ensured through the concept of trustworthiness which was ensured through four criteria: credibility, transferability, dependability and confirmability (Nieuwenhuis, 2016c:123), each which will be discussed subsequently:

3.5.4.1. Credibility

Credibility was apparent throughout the study, by ensuring that the results found regarding the spiritual factors of Charismatic Christianity influencing health-seeking behaviour were consistent with the reconstruction and representation of the results from the researcher (Schurink, Fouché & De Vos, 2011:420). The researcher ensured this by using the following strategies: firstly, the researcher employed purposive sampling and semi-structured interviews to achieve rich, detailed

descriptions from a sample that was familiar with the phenomenon (Nieuwenhuis, 2016c:123). Secondly, the researcher had consistent debriefing sessions with her supervisor via email to ensure that the representations were accurate and credible (Schurink et al., 2011:420). Lastly, the researcher used thick descriptions to ensure that the research findings were accurate, comprehensive and trustworthy (Lietz & Zayas, 2010:198).

3.5.4.2. Transferability

Transferability was ensured through trustworthiness, as it allows people to make connections between the research and their own subjective experiences, thus due to the fact that this was a qualitative study, generalisability was not possible (Nieuwenhuis, 2016c:124). To ensure transferability the researcher used thick descriptions to have a thorough representation of the findings and purposive sampling which ensured that the sample met the criteria for what was being studied (Lietz & Zayas, 2010:198).

3.5.4.3. Dependability

The researcher also ensured dependability by ensuring that the research process was logical, audited and documented (Schurink et al., 2016:420). The researcher used the audit trail strategy which ensured that the criteria for dependability was met by recording all decisions and actions made throughout the research process, including the interviews. The researcher also documented the process of thematic analysis with the coding for the themes and sub-themes (Nieuwenhuis, 2016c:124; Lietz & Zayas, 2010:198).

3.5.4.4. Confirmability

Lastly, in order to achieve trustworthiness, the researcher ensured confirmability, meaning that there was neutrality in the study, indicating that the research findings were influenced purely by the participants and not by the researcher's personal bias (Nieuwenhuis, 2016c:125). This was achieved by reducing researcher bias, and by recording and transcribing all interviews, verbatim.

3.5.5. Pilot study

A pilot study was conducted to allow the researcher an opportunity to orientate themselves towards their prospective study (Strydom, 2011a:236). The pilot study served as a test for the data collection instrument, which was the semi-structured interview schedule. This allowed the researcher an opportunity to identify any potential problems that needed to be corrected before the implementation of the actual semi-structured one-on-one interview (Christensen et al., 2015:356).

The pilot study was a trial run of the entire study with two participants, who were similar to those in the sample for the study (Christensen et al, 2015:285). The participants in the pilot study were requested to identify ambiguous questions within the semi-structured interview schedule, they also needed to identify any comprehension or language issues which may have been confusing or misleading for the participants, these were discussed during a debriefing session (Christensen et al., 2015:285).

The pilot study that was conducted by the researcher, included two participants from New Creation Family Church, who were over the age of eighteen and identified themselves as Charismatic Christians. After conducting the semi-structured one-on-one interview, a debriefing session was held with each participant, which included a detailed discussion regarding the semi-structured interview schedule. All changes, challenges or predicted problems were addressed prior to implementation of the data gathering process. The data collected within the pilot study was of a rich nature, as such, it was also included in the main data set. As such, both interviews of the pilot study were included in the data set.

3.6. ETHICAL CONSIDERATIONS

Ethical considerations were of importance for the study, as the study dealt with human participants and explored their experiences, opinions and beliefs. This study needed to receive ethical clearance from the Faculty of Humanities Research Ethics Committee, University of Pretoria, prior to commencement. The researcher adhered to several ethical considerations, including: Avoidance of harm, voluntary participation, no deception of respondents, confidentiality, no compensation, as well as, the publication of findings.

3.6.1. Voluntary participation and informed consent

All participants only participated in the study if they had volunteered to do so, thus, **voluntary participation** was ensured. This was achieved by firstly, explaining the research project to the potential sample, they were then given an opportunity to choose whether they would participate or not (Strydom, 2011b:116). Voluntary participation was employed, in conjunction with **informed consent** of the participants (Christensen et al, 2015:125). Informed consent consisted of a written document that explained the goal and purpose of the study and included any areas where potential harm may occur, this was then explained to participants. This included that the interview would be recorded with their permission and that the data would be stored for 15 years for archival or research purposes. If they were willing to participate and consent, they signed the letter of informed consent - attached as Appendix 3 (Babbie, 2017:66).

3.6.2. Avoidance of harm and debriefing

The researcher ensured **avoidance of harm**, both physically and emotionally, throughout the duration of the study, and as such, the researcher needed to be well aware of the possible causes of harm and how to reduce these risks (Strydom, 2011b:115). In the case of possible emotional harm, all participants were afforded the opportunity to be **debriefed** by the researcher after the interview. If it was found that the participant required therapeutic intervention, they were referred to Beverley Beukes, a social worker at Oasis Haven, Randburg (Babbie, 2017:64) with whom arrangements were made beforehand – letter attached – Appendix 6. These services were not utilised by participants as counselling was not necessary.

3.6.3. Deception and compensation

Related to voluntary participation is **deception,** this was avoided during the study by ensuring that no covert methods of data collection, or a misrepresentation of the research occurs, thus the results remained true. Also related to deception, is that no participant was deceived during any stage of the research process, to ensure rapport and exchange of information (Neuman, 2014:151). Deception was minimised in the study by providing the participants with the basic details related to the study and details regarding the research procedure in the consent forms (Babbie, 2017:66). Lastly, to ensure that participation is truly voluntary, no **compensation** was provided in terms of monetary value (Christensen et al., 2015:133), nor any incentives.

3.6.4. Confidentiality, privacy and anonymity

Confidentiality was ensured during the study by saving and keeping the audio-recordings and the transcriptions in confidence, as such, they will not be made available to the public, only to those involved in collecting and analysing the data. Confidentiality was also ensured during the publication where results are presented with the exclusion of participants' names and identifying particulars (Neuman, 2014:155). Participants were made aware that data would be stored for 15 years.

Related to confidentiality is **privacy,** the venue used for the interviews was private, and with regards to access of information about the participants, as previously stated, only those involved in the collection and analysis of the data, namely the researcher and supervisor had access to the information provided by participants (Christensen et al., 2015:134).

Anonymity was not maintained as the researcher had in-person contact with the participant during the semi-structured one-on-one interview (Christensen et al., 2015:134). Despite this,

pseudonyms were used, to protect the identity of the participants throughout the process. These names were assigned to the participants prior to the commencement of the interviews.

3.7. EMPIRICAL FINDINGS AND THEMATIC ANALYSIS

Empirical data was collected using an interview schedule and ten one-to-one semi-structured interviews with selected participants, who attended the New Creation Family Church in Randburg were conducted. These interviews were voice recorded and transcribed, in order to gain knowledge regarding the factors influencing the health-seeking behaviours of Charismatic Christians. Each transcript was then analysed and coded generating various themes and sub-themes, presented in Table 3.2.

3.7.1. Biographical profile

Table 3.2 depicts the biographical data of the participants who participated in the one-to-one semi-structured interviews. Each participant was given a pseudonym as a measure to anonymity during the research process.

Table 3.1: Biographical profile of participants

Pseudonym	**Age**	**Gender**	**Marital status**	**Number of children**	**Home language**	**Highest qualification**
Thandi	56	Female	Divorced	1	English	Diploma
Naledi	30	Female	Divorced	0	English/ Afrikaans	Bachelor's Degree
Mary	71	Female	Widowed	4	English	Post-graduate Diploma
Melody	38	Female	Married	2	English	Bachelor's Degree
Phillip	36	Male	Married	1	English	Honours Degree

Claudia	35	Female	Single	3	English	Bachelor's Degree
Kevin	21	Male	Single	0	English	Matric
Quintin	32	Male	Single	0	Ndebele	Bachelor's Degree
Amahle	39	Female	Married	1	English	Bachelor's Degree
Wyatt	24	Male	Single	0	English	Bachelor's Degree

The biological profile of participants indicated that 60% of participants were female, while 40% indicated that they identified as male. As such, perspectives from both genders were represented, however, no participants indicated their gender as other, thus other gender groups were not represented. Furthermore, participants' age ranged between 21 years and 71 years, thus representing the views of the different adult life stages, with 20% of participants aged 20-29 years, 60% between 30-39 years, 10% between 50-59 years and 10% between 70-79 years. As such, the largest age group of participants was the 30-39 year age group.

As family structure was found to affect health-seeking behaviour in Chapter two's literature review- 2.3.3.2. Socio-cultural factors influencing health-seeking behaviour, the family structure of participants was investigated: 40% indicated that they had never been married , which was the category with the highest response, 30% indicated that they were currently married, 20% indicated that they were divorced and currently not married, and 10% of participants indicated that they were divorced, the lowest category. In conjunction with this it was also reported that 40% of participants had no children, 40% of participants had 1-2 children and 20% of participants had 3-4 children.

It was found that 90% of participants indicated that English was their home language, this would have been beneficial for them as the interviews were conducted in English, thus limiting language barriers. Although fluent in English, 10% of participants indicated that Ndebele was their home language. Furthermore, 90% of participants had completed tertiary education in the form of: a Bachelor's degree (60%) – the highest category; a diploma (20%), an honours degree (10%),

while 10% of participants had only completed their formal school with a matric. As such, it can be said that the majority of participants were well educated.

3.7.2. Thematic analysis

Subsequently the thematic analysis of the themes and sub-themes are discussed, providing verbatim quotes from the interviews and literature substantiation to support the findings.

Table 3.2: Themes and sub-themes

	Themes	**Sub-themes**
1	Approaches in health-seeking behaviour	1.1. Self-care and non-professional advice 1.2. Lifestyle choices 1.3. Seeking professional healthcare services
2	Factors influencing health-seeking behaviour	2.1. Political influences, structural resources and modern medicine 2.2. Socio-economic factors 2.3. Family structure and socio-cultural factors 2.4. Interrelationships and individual factors 2.5. Spiritual factors
3	The value, beliefs and practices of Charismatic Christianity	3.1. Church practices, biblical and pastoral teachings 3.2. Spiritual grounding, comfort and guidance 3.3. Miracles and healing vs. medical intervention 3.4. The presence of spiritual attacks and the disregarding of physical and mental illnesses
4	Social work in the healthcare setting	4.1. The lack of interaction with and knowledge regarding social workers in healthcare settings 4.2. The potential role of social workers in integrating health and spirituality in healthcare settings.

The themes and sub-themes presented above will subsequently be discussed in detail using verbatim quotes from participants, as well as using literature to substantiate the findings. Firstly, the biographical information of participants will be provided.

3.7.2.1 Theme 1: Approaches in health-seeking behaviour

Health-seeking behaviour is seen as the actions undertaken by individuals in which they partake in curative actions to ensure recovery from what they have perceived as ill (Mahmood et al., 2009:69; Abaerie, 2016:1). This is usually achieved through goal-directed behaviours including lifestyle changes, preventative care and seeking of healthcare services (Grobler et al., 2013:23).

The following verbatim quotes from interviews support this theme. The names used are pseudonyms.

> *Mary: "It would mean that I would um, direct my behaviours or my doings to lead a more healthy life, strengthening my body and to keep things alive for longer."*
>
> *Thandi: "Health-seeking behaviour is just basic, um, basic human behaviour to be mind-healthy, body-healthy."*
>
> *Melody: "Health-seeking behaviour would be…I think it's seeking to live a healthy lifestyle and to be healthy in yourself, like yeah emotionally healthy, physically healthy, yeah."*
>
> *Amahle: "I would define it as um, someone who wants to look after their physical and mental health and seek out ways to do it um, that, that's classified as a norm, as a norm of being healthy."*

Similarly to the description of the above theme, participants defined health-seeking behaviour as goal-directed behaviour to ensure less health complications through lifestyle choices that positively influence physical, mental and emotional well-being.

Throughout the interview process participants continually discussed various approaches in health-seeking behaviour, as will be seen in the following sections. Although approaches varied slightly among participants, the following sub-themes were common among participants. These included, self-care and non-professional advice, lifestyle choices and the seeking of professional healthcare services. In the following sections each sub-theme will be discussed, verbatim quotes provided and literature used to support the findings.

- ***Sub-theme 1.1: Self-care and non-professional advice***

Self-care and non-professional advice is inclusive of behaviours that do not derive from professional healthcare practitioners. These are behaviours that are engaged in by an individual for the purpose of treating symptoms of illness, usually through the process of self-medication, advice from family or friends or the use of the internet. Furthermore, self-care is the actions or decisions an individual takes to minimise stress, anxiety, unhealthy behaviours or symptoms

experienced by illness (Riegel et al., 2017:2). It was recommended by Riegel et al., in a conference that individuals should be encouraged to engage in self-care and rely on care partners (family or friends) that help manage symptoms and ensure adherence to treatment programmes. It was however, noted that there are limitations in self-care related to a decline in mental health or in the case of life-threatening chronic conditions, and should therefore, not replace professional healthcare services (Riegel et al., 2017:4-5).

The following verbatim quotes from interviews support this sub-theme:

> *Thandi: "Well if I was feeling a certain way and I Google and it said because of this, this and that. I would try the thing that they suggest. Um, and if that doesn't work then, then doctor."*
>
> *Melody: "Well my husbands like "here, Vitamin C", he's like the medicated, person that medicates us in our house to go, all the vitamins and usually that kind of thing…So I think that's definitely like self-care, is probably the first, the first step."*
>
> *Kevin: "Well I mean I don't seek help very often I normally kind of keep it to myself unless a) I need something so for example like medication that I don't know what to take then I will ask my mother like ok I have a headache do you have tablets or something…I think my family is quite er Mr web MD's themselves – they know everything and every disease so you can just mention something small and they start running down the list of is it this, is it that, is it this so I think that also contributes a lot to how seriously I would take something."*
>
> *Quintin: "I usually um look up my symptoms on the internet and based on what I see um will try and you know gauge them for another 24 hours and should there be no improvement or should it get worse I will then have to make the decision to go see a general practitioner."*

Participants indicated that that seeking professional healthcare was not usually their first step in the health-seeking process. Participants generally rather sought advice from non-professional persons and engaged in various forms of self-care, including, self-medicating, natural healing and prayer.

Participants indicated that at the onset of illness, they would initially use their own intuition about how to treat the current illness. Participants indicated that they knew their bodies well and were able to decipher whether their illness was serious enough to warrant professional care. Furthermore, if participants were unsure of what their illness was or whether they needed professional care they would often consult their friends, family or the internet for advice, prior to seeking professional healthcare. This type of behaviour was typical in the early stages of illness but if symptoms did not dissipate or they became more severe, participants would usually seek

professional healthcare services. Similar results were found by Musoke et al., 2014:1051, who indicated that individuals were more likely to engage in health-seeking behaviour if they had experienced symptoms over a long period of time, or if they experienced several symptoms at the same time. Also in a Review conducted by Bennadi (2013:20), it was reported that in Punjab, India 73% of the population engaged in self-medication, which was especially prevalent if individuals were well-educated. The theoretical framework supports these findings, as the health belief model indicates that in order for a person to choose a specific health behaviour, they would need to experience a health concern, to which they feel susceptible to and they would need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences (Rosenstock et al., 1988:177). As such, if the individual believes that self-medication will be successful in eliminating illness, they will engage in this behaviour, especially if the consequences of self-medication are less than those of seeking formal healthcare.

The following verbatim quotes from interviews support this sub-theme further, by highlighting that self-care is usually engaged in prior to seeking formal healthcare services as discussed below.

> *Melody: "Yeah, you know for us it would be so easy being like, middle class or whatever, as people we can get on to Google, we can go to Dischem, I mean before even getting to antibiotics there's so much stuff that we can take that we can try make ourselves feel better before we get to the point of actually needing to seek like professional help."*
>
> *Phillip: "I think if I'm in pain, if I am not feeling well and I can't self-medicate, so, then I would do. So I would generally prefer to look after myself, so if I've got a fever or a cough or something I'll try sort myself out. If I can't then I will go or I'll [seek professional healthcare] if I can't get rid of what I have, then I'll [seek professional healthcare], depending on the seriousness of it."*
>
> *Quintin: "Depending obviously on what I'm feeling – if it's something that I recognise as, as, as a flu or general disease I usually self-medicate, but if I feel that it is a bit more advanced or that it is a bit more painful than usual then I will make the decision to go see a doctor."*
>
> *Amahle: "It depends what, what's wrong with me. Like if I'm, if I know I'm sick and I have flu I will self-medicate. I think I know myself pretty well to know when I don't need to seek uh, healthcare. When I can I tend to treat it myself first. Or otherwise um, if it's a, I mean if it's a serious problem that I know I need help, I'm very quick to seek medical advice. Um, so I think I know myself pretty well to know if I, first if I can try and treat it myself or um, seek healthcare."*
>
> *Wyatt: "If I'm just like sick for two/ three days or like I take a day of leave off work, I won't necessarily go to a doctor. I'll just maybe get some over-the-counter meds and then just rest and wait for my body to nurse itself back to health. But if I'm not*

better after, I give myself two or three days, if I'm not better and I feel it's getting worse, I don't waste time and I just go straight to the doctor"

Mary: "You know I always go to my vitamins and everything, I take extra, Vitamin C and all that…Pray, first of all pray. I do actually get prayer first…Because it, I'm trusting in faith. And um, I'm, I'm not the one quickly to rush to the doctor or to take medicines, I take the vitamins but not medicines but I will if I have to."

At the onset of illness participants would frequently engage in the process of self-medicating with non-prescription medication, such as, over-the-counter medication, natural remedies, vitamins and minerals or alternative methods such as prayer or relaxation. If symptoms progressed, participants would then generally seek professional healthcare services. This behaviour was expected as, South Africans are reported to engage in self-care, alternative and complementary medicine, as well as, visits to traditional healers (Abaerei, 2016:3). Furthermore, a review conducted in India by Bennadi (2013:19) indicated that 73% of individuals appear to engage in a process of self-medication, including, taking drugs, natural medicines or home-remedies. Either as a result of their own initiative, or through the advice from others, without consulting professional healthcare services.

The theoretical framework supports the above findings, as the Health Belief model indicates that in order for a person to choose a specific health behaviour, they need to experience a health concern, to which they feel susceptible to and they need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences (Rosenstock et al., 1988:177). As such, if the individual believes that self-medication will be successful in eliminating illness, they will engage in this behaviour, especially if the consequences of self-medication are less than those of seeking formal healthcare. Furthermore, Social Learning theory provides an understanding of why individuals would engage in self-medication, this stems from the belief that if behaviours lead to a reward an individual would be more likely to engage in the behaviour (Cacioppo & Freberg, 2013:587; Chavis, 2011:472). As can be seen from the above participants indicated that in many circumstances self-medication resulted in a relief of symptoms, however, if symptoms were not relieved, thus they were experiencing a punishment, individuals were likely to change their behaviour and seek professional healthcare (Cacioppo & Freberg, 2013:587; Chavis, 2011:472).

- ***Sub-theme 1.2: Lifestyle choices***

The second sub-theme includes the lifestyle choices made by participants that either promote healthy behaviours or health-seeking behaviour or promote unhealthy lifestyles or activities and

inhibit health-seeking behaviour. This sub-theme can be seen as a psychological process that inhibits or encourages health-seeking, by incorporating lifestyle choices and medical intervention (Abongile, 2010:2; Ogden, 2012:7). Participants frequently made reference to lifestyle choices that affected their health.

The following verbatim quotes from interviews support the second sub-theme:

> *Thandi: "When you talk about health, it's you know, eating properly, um exercising to a certain point and not doing any damage to your body…I walk a lot, I drink a lot of water, I walk a lot, I try and eat healthy,"*
>
> *Naledi: "I, um, eat more balanced now. But um, I'm not a big exerciser but I do know it's important because, yeah, balance is important. But, um, yeah, I eat lots of vegetables. Sweets are my downfall. I know that's the problem but yeah, I do try eat a variety."*
>
> *Melody: "I try to exercise, it doesn't always happen but I try… Eating I'm like, I'm a very balanced person so I eat unhealthy and healthy food."*
>
> *Phillip: "So Exercise is always a good one. Eating right, are some of the obvious-y [obvious] ones, and then not taking things you're not supposed to take is another good one."*

All participants referenced healthy eating and exercise as being the main lifestyle choice needed to engage in healthy behaviours. However, despite acknowledging the need for these behaviours, several participants noted that they either do not participate in these behaviours or that they do not participate to the extent that they should, to ensure health. These behaviours were mainly related to physical health which refers to the physiological functions of the human body that are able to work together as a system to meet the needs of the body (Felman, 2017; Bircher & Kuruvilla, 2014:365). Physical health can be maintained through prevention methods such as exercise, accident prevention, developing a healthy diet, healthy sleeping patterns and preventative procedures such as, vaccinations, sun safety and regular mammograms or other screening tests (Taylor, 2015:64). As such, participants have a basic understanding of some physical health prevention methods. However, participants fail to mention engaging in prevention methods related to the formal healthcare system- including, vaccinations and screening tests.

This is encouraging that participants have a basic understanding of preventative measures as the South African healthcare system focuses on primary healthcare with the goal being prevention and screening for early detection of diseases (Englebrecht & Van Rensburg, 2012:483). It is further encouraging that participants participate in some of these preventative measures, thus, contributing to the primary goal of Primary healthcare in South Africa. However, at this point it is

not clear to what extent participants have an understanding of preventative measures, nor to what extent they are willing to engage in preventative behaviours, as such, future research would need to be conducted to gain a better understanding. The participation of participants in preventative measures is in contrast to a study conducted in Ireland by Deasy et al. (2014:77; 85), where it was found that a large portion of individuals did not exercise (26%) or eat a balanced diet (26.3%) and engaged in risky behaviours including alcohol consumption (93.2%), smoking (17%) and cannabis (11.6%) use. This in contrast to this research study that has found participants engaging in exercise and healthy eating while trying to actively avoid risky behaviours- which will be discussed further in the following section:

> *Thandi: "Not doing any damage to your body with substance abuse, that kind of thing."*
>
> *Phillip: "Copious amounts of sugar, drugs, well drugs just in general, alcohol, uh…I'm trying to think of what things you should not take, um, uh…yeah, anything in excess, I suppose is always also a bad thing."*
>
> *Quintin: "To maintain good health I work out – I try by all means to stay away from things that I know cause issues with me, such as food items and or anything that can trigger my allergies."*

Furthermore, some participants mention abstaining from or limiting certain behaviours that can negatively affect health and well-being. These behaviours are characterised as risky behaviours and include drinking, smoking and taking drugs. Other participants noted that abstaining from activities that are known to cause personal health problems are also crucial in maintaining good health. Participants attribute abstaining from certain behaviours as a result of their spiritual beliefs, which were influenced by the teachings of Charismatic Christianity, this will be discussed in greater detail in the following sections. This can be linked to the theoretical framework's social learning theory, whereby it is theorised that through the process of socialisation individuals imitate and observe the behaviours of those around them (Pratt et al., 2010:768). As such, differential association within the Charismatic Christian community would lead to a process of individuals observing abstinence from risky behaviours, due to spiritual beliefs, this would in turn lead to imitation of this behaviour, thus individuals would be less likely to partake in risky behaviours (Pratt et al., 2010:768).

Similarly, in a review of over 100 studies conducted by Koenig (2012:7), it was viewed that individuals who have spiritual belief systems that advocate against certain behaviours i.e. smoking, are more likely to abstain and live healthier lifestyles. Furthermore, it was found that in over 20 studies, there was an indication that highly spiritual individuals were more likely to engage in exercise and healthier diets (Koenig, 2012:7). Spiritual factors may indicate why findings in the

above studies differed to the findings of Deasy et al. (2014:77; 85), where it was found that a large portion of individuals engaged in risky behaviours such as, alcohol consumption (93.2%) smoking (17%) and cannabis use (11.6%).

> *Thandi: "It's just being in a healthy environment, with…with people that um, that lift you."*
>
> *Melody: "And emotionally to be involved in obviously church life, have friends and have good relationships with family."*
>
> *Amahle: "I prize mental health over physical health. Not that I'm saying I'm not prizing it [physical health] but um, but I believe mental health is much more important in my personal life experience."*
>
> *Wyatt: "So health- I look at it broadly, so not just my physical health but also my mental health. Um and whether or not I feel lonely, whether or not I feel motivated these are all like factors that I consider when I consider my health… Mental health is making sure I have a support system. You know, being connected in church, um if things are really bad, you know going for a few sessions with a psychologist. Um, and yeah, other things like avoiding being lonely. So reaching out and just being connected in the community.*

In conjunction with physical health, participants also referred to health behaviours that are needed to enhance mental health. These behaviours were mainly related to the limitation of stress and the need for social support within the community. This is in contrast to the findings of a study in Kenya, conducted by Abubakar et al. (2013:4) which found that individuals were less likely to consult the formal healthcare sector for illnesses believed to be mental illnesses, as they would rather consult traditional healers. Within this study no participants made reference to contacting traditional healers or spiritual elders for maintaining physical or mental health. This may be due to cultural differences between the research groups.

The above findings are supported by the Social Learning theory, which suggests that individuals imitate and observe the behaviours of those around them (Pratt et al., 2010:768). As such, differential association within the Charismatic Christian community would lead to a process of individuals observing abstinence from risky behaviours, due to spiritual beliefs, this would in turn lead to imitation of this behaviour, thus individuals would be less likely to partake in risky behaviours (Pratt et al., 2010:768). As such, this could explain why findings differed from other studies, as the participants in this study were influenced by the Charismatic Christian community in Johannesburg, which was not evident in the other studies from the literature review. Furthermore, the Health Belief model provides an explanation for why individuals may understand preventative behaviour but not always engage in the behaviour fully. If an individual does not perceive themselves as susceptible to disease or does not recognise the benefits of preventative

behaviour, they will be less likely to engage in such behaviour (Carpenter, 2010:3; Rosenstock, 1974:331).

- ***Sub-theme 1.3: Seeking professional healthcare services***

Professional healthcare services are derived from allopathic medicine, which aims to identify new diseases and effective treatment methods to ensure its original purpose, it can be practiced in primary, secondary and tertiary healthcare levels, but individuals are encouraged to engage in allopathic medicine from the primary level of prevention and screening (Pretorius, 2012:594). Participants within the study reported that they would all utilise professional healthcare services if necessary, however there were two main approaches of when to seek professional healthcare.

The following verbatim quotes from interviews support the third sub-theme:

> *Thandi: "Well if I was feeling a certain way and I Google and it said because of this, this and that. I would try the thing that they suggest. Um, and if that doesn't work then, then doctor."*
>
> *Naledi: "So before I went to go see the psychologist now [2019-2020], it probably took me, I probably should have done it when I was about thirteen years old and I lost my mom. So it took me many years before I actually did it. I did try at varsity when I was about nineteen years old but I just didn't relate to the person."*
>
> *Naledi: "If I know something is really wrong I'll very quickly see a doctor. I don't delay that, um, and, and, mentally now, I'm very aware of my thought patterns and all those things, so yeah, I'll just make an appointment and go and see him [psychologist] as well."*
>
> *Mary: "I'm very slow to apply it, to actually get [medical treatment], you know what I mean?"*
>
> *Melody: "So I make sure I'm really sick before I go. So I probably would take like a week maybe. Um, emotionally, like I think I always have, I have people that I can talk to when I feel like I need the help that I probably also prolong it and wait probably too long."*
>
> *Phillip: "I think, pain I go quite quickly, like if I'm in pain I'll go to physio or a doctor or a whatever quite quickly, within, within the day. If I'm just not feeling well probably a few days, you know? Two, Three, Four days."*
>
> *Claudia: "It takes convincing from actual healthcare providers that I know. Uh, it takes me absolutely feeling like death [to seek healthcare]."*
>
> *Amahle: "If it's a serious problem that I know I need help, I'm very quick to seek medical advice."*

Several participants sought professional healthcare after a period of two to seven days, in the event that physical symptoms remained or worsened during this time. In the case of mental health, some participants reported waiting several years before seeking help. Some participants also

reported that seeking professional healthcare was a last resort and would only be done in the event that other methods had not been successful. The length of waiting depended on several factors which will be discussed in the following section. As previously stated, this coincides with a study in Yemen, conducted by Webair and Bin-Gouth (2013:1135), found that if symptoms are severe, individuals are more likely to seek formal healthcare, despite the increased effort, as remaining severely ill appears to be more of a burden than finding healthcare. However, if symptoms are mild - moderate individuals are more likely to seek simpler methods (Webair & Bin-Gouth 2013:1135). As such, this could explain why individuals with mild - moderate symptoms are more likely to self-medicate or ask friends for advice than to seek professional healthcare.

This can be further explained through the Social Learning theory, which theorises that individuals are expected to make decisions when confronted by various situations. Through this direct experience, individuals will learn that certain responses result in favourable outcomes, while other responses may lead to less favourable or undesired outcomes (Bandura, 1971:3). As such, it is expected that if individuals experience severe symptoms, thus leading to unfavourable consequences, they would learn through direct experience to engage in health-seeking behaviours more quickly, when experiencing similar symptoms in the future through the process of reinforcement (Pratt et al., 2010:768).

Secondly, other participants indicated that if they perceived certain physical symptoms as abnormal, or in the case of mental health, felt that they were unable to cope, they would seek professional healthcare immediately. As such, it appears that participants usually engage in professional healthcare systems at the secondary and tertiary levels, thus only using professional healthcare services for diagnosis, therapeutic support and specialised medical services (Erdmann et al., 2013:133; South African Government, 2019). This is further supported by the Health Belief model as it theorises that individuals who perceive symptoms as severe, or who perceive healthcare as beneficial would be more likely to engage in health-seeking behaviour (Rosenstock, 1974:331).

> *Naledi: "I saw a psychologist for a yearlong last year. To take care of my mental health."*
>
> *Melody: "Yeah but then yeah the GP or a counsellor. I have a counsellor that I like to see every now and again."*
>
> *Claudia: "I would go to a counsellor but obviously she can't subscribe [prescribe] medicine but, yeah, I go to counsellors. And a doctor, yeah, just a general doctor."*

Amahle: "I call a doctor and make an appointment. Uh, the type of, so usually it would be a GP or something. Yes something similar and then if uh, I need uh, a professional, uh specialist help, I will take it from there and ask well who should I go and see and then make an appointment."

When seeking professional healthcare for physical health, participants were most likely to book an appointment with a (General Practitioner) GP. However, in certain cases they also made use of other healthcare professionals such as physiotherapists, nurses or medical specialists, such as surgeons. In terms of mental health participants usually received care through counselling, with reference to psychologists, counsellors and psychiatrists.

Wyatt: Once I go to a healthcare professional, depending on what it is, so if it's like a back injury, I go to my physio, if I'm feeling sick I go to my, my GP, then I will obviously follow their guidance and what they have to say.

*Mary: "*Freddy [husband] took chemo, he always thought he wouldn't and then he had chemo. The second time round he said "I don't want chemo again". And that was because he so hated the whole ambiguity and, and junk he went through with it. So he said "I'd rather die"."*

Mary: "But then I found the Cortisone, cause it made me like, wildly, uh, um, bumping into things so I reduced the dosage myself to what seemed okay. And then went down. But I had a heavy chest, a high bit of fever all the time, sweating, we managed, we managed. And then I recovered."

Some participants indicate that when they receive professional healthcare they are likely to follow treatment advice until they have restored their health. However, other participants indicated that even after receiving professional healthcare services, they were likely to become non-compliant with treatment plans. It was also reported that in some cases individuals who were receiving professional healthcare treatments may choose to discontinue treatment as a result of side-effects, predicted outcomes or personal beliefs. In a Danish study, Friis et al. (2016:8) found that individuals were more likely to engage in health-seeking behaviours if they understood health information. It was further reported that individuals with long-term conditions reported a lack of understanding health related information and were therefore less likely to engage in formal healthcare (Friis et al., 2016:8). As such, this could indicate why some individuals are more likely to complete and abide by treatment methods, while others are more likely to be non-compliant and stop treatment plans. This can be further explained through the Health Belief model which indicates that if individuals perceives treatment as either not providing effective benefits or causing negative consequences that they deem as a risk, they would be less likely to continue treatment methods (Rosenstock, 1974:331). However, various other factors may also play a role, as such, this will be discussed in the following section.

3.7.2.2. Theme 2: Factors influencing health-seeking behaviour

Throughout the research study, various factors that influence health-seeking behaviour were highlighted by participants, thus becoming the second theme of the research study. Similarly to what was found in the literature review, factors were classified in five sub-themes. These included, political influences, structural resources and modern medicine; socio-economic factors; family structure and socio-cultural factors; interrelationships and individual factors; and lastly, spiritual factors. Each sub-theme will be discussed in detail providing both verbatim quotes and reference to previous studies.

- ***Sub-theme 2.1: Political influences, structural resources and modern medicine***

The first sub-theme is representative of the factors directly related to the South African government, their policies and the structural resources available to citizens. This sub-theme further includes how the advances in modern medicine have influenced health-seeking behaviour, as is discussed below.

The following verbatim quotes from interviews support the first sub-theme:

> *Thandi: "I've never had an issue with my current GP…I phoned at 14:00 and just said is there a late afternoon appointment with * Dr V and yes, boom, there was one at 16:30. I've never had an issue getting an appointment. Um, 99% of the time I've been able to see my own doctor and if she wasn't available and it was urgent enough I can see, there's always someone available… I've even walked there before. So it's about 2K's. [Kilometres] from my house."*
>
> *Naledi: "Oh everything. Yeah. Psychologists, psychiatrists, hospitals, doctors, all of those…So I work in Sandton and he [psychologist] was in Fourways and I live in, at that stage I lived in, um, Sharonlea and so it was quite far but um, yeah, I made the trip and did it… In a private car."*
>
> *Melody: "Yeah, but even like driving to the doctor, it's like so easy for us. You get in the car, 10 minutes and you're there."*
>
> *Phillip: "I think there's some better clinics within the community, um, there's a medical centre both at Cresta and up the road so I think there's some, some actual medical places. And within the community as well that I am, obviously as a church we have, we have um, you know um, access to psychologists, psychiatrists, um counsellors just on their own, social workers, um yeah, so I think there are those. Um, I, I, I know in the area are some gyms um and some dieticians and physio's and things like that."*
>
> *Kevin: "Yeah we have a dentist and …. Look we are middle class – upper middle class so we have all the luxuries. We have pharmacies that can dispense over the counter medication for at home use. We have dentists, doctors everything…I mean we all have either access to a car, or our own car, we have medical aid so there is nothing really stopping us in terms of that."*

Wyatt: "I have a GP, um psychologist, there's a free psychologist service offered to me at work. So I can call them and set up appointments and it's completely free. Um, I have a physio-therapist and I have a chiropractor, so those are my four main. Um, so that covers everything. That covers injury, bodies health, mental health."

Participants reported utilising healthcare services that were easily accessible with relatively few challenges. As such, it can be assumed that structural resources are not generally a factor that discourages the participants from accessing formal healthcare services. As participants live within the South African context, it was expected that self-care, alternative and complimentary medicine and traditional medicine, would act as an impediment to seeking formal healthcare (Abaerei, 2016:3). However, this does not appear to have affected participants as they report accessing various medical professionals including, general practitioners, dieticians, physiotherapists, pharmacists, clinics and private or government hospitals. Furthermore, participants report that they experience few impediments in accessing these resources. They report easy bookings of appointments, quick healthcare and ease in transport - due to either proximity of services or access to private transport. They also report an abundance of options, specifically in the private sector, however, they also have access to public healthcare if needed.

In a Johannesburg study, Abaerie (2016:5) found that when an individual experiences dissatisfaction with health-care services, especially those provided by the government, they are more likely to be discouraged from seeking formal health treatments (Abaerie, 2016:5). This may indicate why the participants access formal healthcare services when necessary, as they report that the healthcare services that they are engaged in are easily accessible with relatively few challenges, thus making them more likely to access these services. Furthermore, a Kenyan study by Abubakar et al. (2013:1) found that in inadequate, under-resourced and under-staffed medical facilities individuals are less likely to seek formal healthcare, especially if their symptoms are perceived as mild to moderate. As such it is expected that participants would access healthcare resources within their community, as they report none of the above challenges. Furthermore, the Social Learning theory indicates that through the process of direct experience, individuals are able to learn which behaviour will result in desired outcomes (Bandura, 1971:3; Williams, 2010:1). As such, when individuals are less likely to be satisfied with the outcomes of seeking professional healthcare, such as long waiting times or non-service due to lack of resources, they would be less likely to engage in this type of behaviour again, therefore seeking alternative health practices. This is further supported by the Health Belief model which theorises that individuals will only engage in health-seeking behaviour's if they are seen as beneficial with few negative consequences (Rosenstock, 1974:331).

Kevin: "I mean for the most part yes – I think so obviously we live quite close to um an area that's not necessarily poor but isn't necessarily as well off as us – they would probably have to walk to a free clinic and wait in line for a couple of hours to get the same thing that we could get could probably get in 10 minutes."

Quintin: "There are quite a few private hospitals around as well as government hospitals as well as um private practice doctors who occupy rooms close by. So there's, there's various options which we are extremely grateful to have because depending on your situation you are in a better position to at least seek some form of assistance… when you look at government hospitals it is the lack of resources and in speaking about the government hospital that's close to where I stay I would say there is definitely over-crowding, there is a lack of resources but above and beyond that you get the, you get the impression that it is not as well-kept and not as well clean if you like as it probably should be. Um which then makes me wonder if people actually are getting the help they need."

Amahle: "back then [12 years ago] we, like everyone else made use of State healthcare and clinics. Which um, I- a lot of people believe it's bad or sub-standard um, which I do not agree with. I just believe it's very over-crowded. Um, and, and, they can't handle it all. So you wait longer to get healthcare… If a, if a medicine has side-effects or it's not making you better, you can't just quickly go back to the doctor… where I teach, the kids who suffer from long term psychiatric problems, there's very little help and limited help in terms of that. In psychiatric problems you or conditions you need to get to know a person and deal with them. If you go to a place like Tara, they are highly inefficient and also um, for kids with um, with uh, who get diagnosed with ADD or ADHD, um, they do not have the variety of medication than what you have in private practice. Um, they only prescribe Ritalin and if you have all the side effects and it doesn't work for you, well tough, that's all they have.

The participants experienced few challenges regarding accessing formal health resources, most of them would attribute this to living middle class lifestyle, thus experiencing certain benefits. However, some participants made reference to challenges that others in their community were experiencing. These challenges were directly linked to public health systems and included limited resources, over-crowding, long waiting periods and limited choice in treatment methods. These challenges were expected due to the fact that South Africa has a low percentage of medical aid schemes within the population, as such public health services are burdened with overcrowding and lack of access to resources, which may affect access and availability to services, as well as the standard of services provided (Abongile, 2010:71). Furthermore, the lack of challenges experienced personally by participants may be linked to the fact that the majority report having a medical aid scheme (Abongile, 2010:71). These results can be linked to the Health Belief model which states perceived barriers, including any negative consequences that health-seeking behaviour may incur, including expenses, effectiveness and level of danger, as such, if individuals are dissatisfied with health services, they would be less likely to engage in them (Carpenter, 2010:4).

Mary: "The last time I was terribly ill and um, I didn't have a car, so it'd mean that I'd have to get one of my children or to Uber to the doctor. And it was one of the coldest three days of the year, so it was a little freak thing of Autumn and I just thought "no I'd rather stay in bed". So I just stayed in bed and I felt a bit better."

Claudia: "I wouldn't say I'd want to book a telly health appointment but I'm more likely to see a doctor if um, if I don't have to get out my bed when I'm sick."

Amahle: "We do have a, a social worker at the school where I work, she's full-time employed there. And um, times where I've tried to work through um, really bad trauma from my past, I did go and, and see her about it. To, to help me because I had access to her and because as an employee of the institution I don't have to pay for her services"

Although participants experienced relatively few challenges regarding accessing health resources in their community, participants appeared to be more likely to access resources if they were easily available to them and required relatively low effort from participants. Therefore, participants were more likely to access resources if they were made available at their place of work or if they did not need to travel to receive services. In a study conducted by Musoke et al. (2014:1050) in Uganda, it was found that individuals who are unable to access formal healthcare services easily are unlikely to utilise these services. Similar results were found in a Yemen study conducted by Webair and Bin-Gouth (2013:1135) that found if symptoms are mild - moderate individuals are more likely to seek simpler methods as seeking formal healthcare may be deemed as unwarranted effort. This study found similar results as participants were more willing to seek healthcare if minimal effort was required. This is directly linked to the Health Belief model which states that individuals who experience relatively few consequences in health-seeking practices, would perceive the behaviour as more beneficial and thus, engage in this type of behaviour more frequently (Rosenstock, 1974:331).

Melody: "I think research, research is like yeah. And, cause even with these vaccines I'm just like no, I'll take my children have had all their vaccines, but so I'd probably say science is my number one."

Wyatt: "I think I trust modern medicine a lot. Um, I look back in the day like during the black plague or something. Like if you cough it meant you were going to die. Um, so I'm thankful we don't like in times like that. Uh, so I, yeah. I think it's just, the time we live in has influenced me a lot."

Lastly, participants made reference to modern medicine. Participants stated that they trusted modern medicine and that they were more likely to access this type of medicine as it is rooted in science and has been thoroughly researched.

- ***Sub-theme 2.2: Socio-economic factors***

The second sub-theme identifies and discusses the social and economic factors of Charismatic Christians that affect health-seeking behaviour.

The following verbatim quotes from interviews support the second sub-theme:

> *Melody: "We have the medical aid would, like for us it's like you don't even blink with a doctor's appointment because they cover how many, you know we haven't used our appointments this year you know? So it's not a question of "what is it? Do I have R400 or R300 for a consultation" it's like you don't even think about it cause the medical aid pays you know."*
>
> *Amahle: "Um, well I believe that um, not I believe, I know that in South Africa a lot of people battle without uh, medical aids. I do know that I'm um, very fortunate to have a medical aid."*

The majority of participants indicated that they had medical aid allowing them to access professional healthcare services relatively easily, as they were able to receive services from private healthcare institutions using their medical aid benefits. It can be expected that individuals with higher education levels are more likely to be employed in positions that provide health benefits, such as medical aid schemes, thus they are more likely to use these benefits (Braveman et al., 2010:386). The participants describe themselves as educated and middle class thus, more likely to have access to health benefits.

> *Thandi: "I had to change before I went onto this plan. I, I had to change my GP. It had to be in your network, in a certain network of practitioners and I was lucky enough to find a great doctor… So I only pay R100 for a consultation [general practitioner]. However if you come out there with five scripts you, you have got to fork that out yourself."*
>
> *Phillip: "Medical aid or my own money depending on if my medical aid savings runs out."*
>
> *Amahle: I do know, even if you do have medical aid, uh, it's very limited in terms of what you can access in terms of psychology or speaking to a psychologist. Um, stuff like that, so uh, that is even a challenge for people like me who have medical aid, um, like if I have certain emotional problem, I want to work through, I can't necessarily just do that with a professional because of um, of financial resources… I think physical healthcare is a lot easier um to, not easy but easier, to access, opposed to mental healthcare where you have to have financial resources. And even when you do have medical aid, it's very limited in terms of what they can cover. Even if you have a medical savings account. If you see, if you have six appointments with a psychologist for the year, that's your entire medical savings gone. Or two with a psychiatrist.*
>
> *Wyatt: "I don't wanna go to the doctor every single time, you're gonna drain your medical aid benefits if you do that."*

Although participants indicated that having a medical aid allowed them to engage in professional healthcare more comfortably, they mentioned several challenges and restrictions linked to medical aids. Some participants found that they needed to receive services from specific healthcare providers or medical aid would not fund them, thus, limiting their choices. Other participants found that medical aid schemes did not fully fund what they required, as such, they would choose to not complete treatments. While others indicated that they would avoid seeking treatments, as they did not want to finish their savings, as they would then enter a self-payment gap which could be financially taxing. Lastly, participants indicated that medical aid was a financial burden in itself, as you not only paid your monthly premiums, but that certain treatments were not covered and was for the members own personal expense. As such, participants largely mentioned financial factors as being the biggest reason for not seeking professional healthcare services. Although participants defined themselves as middle class and having access to medical aid, they still discussed financial aspects as being the biggest impediment to receiving professional healthcare.

> *Naledi: "I think financially it's a lot of money, um but I think if you find the right fit and the right psychologist and it works, then it works. So the cost outweighs the ug, uh, the benefit outweighs the cost but it is very expensive. Especially, I mean, I saw once a week for probably nine months. It's like R1000 a week."*
>
> *Wyatt: "Yeah, cost wise. I mean it's, it hasn't stopped me from going but I can't, can't go to the physio every week."*

Despite some participants feeling that professional healthcare can be a financial burden, some felt that the benefit of receiving the treatment outweighed the cost factor, as such, if they saw the treatment as beneficial they were willing to pay for the services. This is further supported by the Health Belief model which states that if individuals perceive benefits, which includes whether or not an individual views the recommended healthcare as feasible and beneficial, with less consequences, than if they left the illness untreated, they are more likely to engage in professional healthcare services (Rosenstock, 1974:331).

> *Kevin: "Oh yes 100%. with the price of all of those things if you don't have a good medical aid or a lot of money you are not going to get anywhere near good health care".*
>
> *Quintin: "The obvious one [factor] would be um finances. The more or the less finances you have you are more likely to try and avoid spending money on, on, on seeking medical assistance – which can be to your detriment in some instances."*

Although most participants have access to medical aid, they do note that there are others within the community, who do not have access to medical aid or alternatively, to large money sources.

Participants reported that these individuals would then either seek healthcare less often or are exposed to poorer healthcare services, thus not benefiting fully from healthcare services, as was intended. Similar results were found in studies conducted in Sub-Saharan Africa, which indicated that a lack of education, the status of being an immigrant and the factor of living in poverty, has contributed to individuals utilising health-care services less often than non-vulnerable groups (Abaerei, 2016:3). Furthermore, Mahmood et al. (2009:73) found that in developing countries, such as Bangladesh, the health-seeking behaviour of the poor is limited to affordability of health services. Expenditures of transport, medication and consultation may act as a deterrent for individuals when seeking healthcare. Similar results were found in a study conducted by Musoke et al. (2014:1050) conducted in Uganda and a study by Amin et al. (2010:7) in Bangladesh, which found that individuals living in rural communities, were less likely to utilise formal healthcare systems. These studies may provide an indication why participants noted that individuals in their communities without medical aids and receiving lower income and less likely to access healthcare services, and if they do these services are said to be of poorer quality.

Although not specifically mentioned by participants, a further socio-economic factor could be level of education. All participants had finished schooling and were either enrolled in or had graduated from tertiary education. As such, it can be said that the participants of this study were well educated and could indicate why they frequently access professional healthcare services. These findings would then be similar to Webair and Bin-Gouth (2013:1136) in Yemen which found that educated individuals are more likely to understand media campaigns designed to promote healthy behaviour (Webair & Bin-Gouth, 2013:1136). Similar results were found in Bangladesh, where a study conducted by Amin et al. (2010:8) found that more educated women were able to understand media campaigns, thus having more understanding regarding the severity of symptoms and illnesses. This can be further explained by the Social Learning theory, through the process of socialisation, individuals will be exposed to the behaviour patterns of others, within the community, which helps an individual to define and prescribe to a certain behaviour (Pratt et al., 2010:768). It is expected that certain behaviours will be taught based on the imitation of common role models, while other behaviours will be avoided due to the harm that befell others (Bandura, 1971:5). As previously stated in chapter one, this type of learning will be more prevalent if an individual sees themselves as being similar to the person they are observing and consequently, modelling (Deeming & Johnson, 2009:204). As such it can be expected that individuals with similar education levels and financial status, would be more likely to imitate behaviours within those social groups.

- ***Sub-theme 2.3: Family structure and socio-cultural factors***

The third sub-theme related to the factors that affect health-seeking behaviour is family structure and socio-cultural factors. This includes the role of individuals, norms and values within the family system, as well as, the influence of cultural norms on health-seeking behaviour.

The following verbatim quotes from interviews support the third sub-theme:

> *Quintin: "I would say looking at my family – I would say it's usually my mother but because I am an adult I make my own decisions on that, I do have younger siblings and they usually then will take the advice of my parents but for me personally it's down to me."*
>
> *Kevin: "Um my mother. I mean usually her like my dad will also sometimes have um an input [in healthcare] but it's usually my mother."*
>
> *Melody: "It will probably be *Peter, yeah he'll just be like okay and I'll be like "should we take them"[their children] and he's like "yeah let's just take them" and it's especially if we're like going away or you know? Or it's like a Friday and you're like "well if he gets more sick over the weekend then you can't get a doctor's appointment." But it will probably be a lot more *Peter."*

Participants referred to family structure as being a factor regarding when they would seek professional healthcare. Some participants noted that they were solely responsible for their healthcare and independently made all health-seeking decisions. This was usually in the case of males or unmarried women living independently. Other participants noted that it was the matriarch in the family that made most decisions for the household regarding healthcare. While other participants regarded the patriarch of the family as the sole decision maker regarding the family's healthcare. Lastly, it was also noted that in some families, there was equal participation in decision making. As such, it appears to be dependent on each family's individual dynamics. As findings represent differences in the decision maker of healthcare within families, these findings differ to other studies. Abaerei's (2016:5) Johannesburg study found that although women are the caregivers in family systems they must still abide by their husband's decisions, leaving children to wait longer before healthcare treatment (Abaerei, 2016:5). Furthermore, the results differ from other studies - Webair and Bin-Gouth (2013:1134) conducted a study in Yemen, it was found that health-seeking decisions regarding children were most frequently decided by mothers. While a contrasting study by Abubakar et al. (2013:5) that fathers were more likely to be consulted regarding health-seeking decisions, as they were the breadwinners and thus, the authority figure in the family.

Although depending on family dynamics, gender appeared to play a role in decision making, this did not appear to cause differences in accessing healthcare, as both male and female participants all indicated that they received healthcare when necessary. This is in contrast to a study by Mahmood et al. (2009:73) and a study in Bangladesh by Amin et al. (2010:8), which both found that women were ill more often than men but sought health care services less often than men. These findings also differ from a study conducted by Abaerei (2016:24) in Johannesburg, which found that women were more likely to access health care than their male counterparts.

> *Naledi: "I definitely felt like I knew something was wrong and I needed help. Like it wasn't all just that I felt like I should because I'm going to church. I knew something was wrong. So, and maybe your, my upbringing as well. My dad was very, um, anti-medication, anti-doctor. Like if you have a headache just drink water. So, I think because her, his dad was an alcoholic and abused tablets and was on anti-depressants, my dad chose the path where he like kept us away from all of that. So, now I feel like when there's a problem, I rather want to sort it out."*

It was also noted that upbringing could influence health-seeking behaviour. For one participant in particular, it was noted that due to a disagreement in how healthcare was viewed in their childhood, they made the conscious decision to employ different health-seeking behaviours.

> *Quintin: "Another thing would probably be – as a foreigner – I think um often you find you hear of stories of people not being treated well in in in Government institutions so it does discourage you because you feel like you are going to be exposed to a bit of xenophobia."*

One participant noted that being a foreigner in South Africa can cause an individual to be more cautious when seeking healthcare, as the influence of Xenophobia has caused healthcare professionals to provide different standards of care to foreign nationals, as such, these individuals are less likely to utilise healthcare services.

> *Wyatt: "I think um, there's a societal pressure. So for example, exercise is a health-seeking behaviour and when I was a kid I was very obese and I wouldn't get attention from girls and would get bullied sometimes. So that pushed me into um, into the health-seeking behaviour of exercise… I think it's just a lot of societal influence. I don't wanna be the person who doesn't take care of themselves.*

Furthermore, a participant noted that societal pressure plays a role in health-seeking behaviour. He noted that due to expectations in society some behaviours are encouraged, while others are discouraged. Depending on the society, this influence can either positively affect your health-seeking behaviour, for example exercising and healthy eating; or the influence can be negative such as in alcohol and drug consumption. Individuals would be more likely to be influenced by societal pressures if they exhibited high levels of social engagement and trust, thus find value

within their community (Bircher & Kuruvilla, 2014:373). These societal influences may also explain why no participant mentioned seeking traditional healthcare, even though it is common practice in South Africa. These findings may be further explained by a study conducted by Abubakar et al. (2013:5), in Kenya, which found that younger generations who have adapted to the modern world, are less likely to use traditional healers and more likely to use formal healthcare services. This is due to a belief that traditional healers no longer have relevance in their cultural and spiritual beliefs (Abubakar et al., 2013:5).

These findings may be explained through the Social Learning theory, which suggests that individuals learn social behaviour through a process of observing and imitating behaviour of their social environment (Cacioppo & Freberg, 2013:587; Chavis, 2011:472). As it is expected that health-seeking behaviour can be learnt behaviour, this theory can provide an explanation for gender roles in health-seeking. For instance, if an individual has observed the matriarch of the family taking an active role in the family's health-seeking and the patriarch a more passive role, that individual would be more likely to imitate the same behaviour in their own household (Cacioppo & Freberg, 2013:587; Chavis, 2011:472). Furthermore, this theory may also explain why participants indicated that societal expectations influenced behaviour. As individuals would observe and imitate the behaviours of those within their society. As such, behaviours that provided rewards or limited consequences would be prevalent within the society, which would be observed and imitated by individuals within the society ((Myers, 2013:363; Cacioppo & Freberg, 2013:587).

- ***Sub-theme 2.4: Interrelationships and individual factors***

The fourth sub-theme is defined as the factors affecting health-seeking behaviour that are influenced by personal factors such as personality, values and past experience, as well as by personal relationships including those of friends and family.

The following verbatim quotes from interviews support the fourth sub-theme:

> *Thandi: "I think the person that I speak to the most, um, [is] my sister in Namibia. She would probably be the one that says, you know, "Don't leave it, go and get it sorted out". Um, I think I probably discuss more things with her."*
>
> *Mary: "It's usually, if like there's a number of people saying "*Mary, get yourself to a doctor"."*
>
> *Melody: "I think the people that live close to you are the ones that you're like "okay maybe I should go to the doctor". So it'd be like my husband."*
>
> *Claudia: "Being surrounded by healthcare people, people that are interested. I find, I found myself needing to go to the doctor a lot, like tryna diagnose myself,*

tryna find the answers but uh, actually then not going straight to where I would have gone before. So that would be the other factor is the people that you're surrounded with."

Participants reported that their health-seeking was often influenced by their friends and family. Participants would often speak to important persons in their lives before they would contact a professional healthcare provider. In many cases participants would seek professional healthcare due to advice given by persons they trust. Furthermore, participants noted if they had healthcare professionals within their own lives, they would often seek informal advice from them first and only seek formal healthcare if encouraged to do so by these individuals.

Naledi: "My dad um, doesn't really believe in psychologists and medication and any of that stuff… He very much had the stance that if you, if you just think the problem away then it's gone.

Naledi: "If I know something is really wrong I'll very quickly see a doctor. I don't delay that, um, and, and, mentally now, I'm very aware of my thought patterns and all those things, so yeah, I'll just make an appointment and go and see him [psychologist] as well."

Mary: "If I'm feeling I can make it, um, I usually trust in God. If we, if I'm not, if I'm not very, very ill then I just stick it out."

Phillip: "I think, pain I go quite quickly, like if I'm in pain I'll go to physio or a doctor or a whatever quite quickly, within, within the day."

Participants report that they personally, as well as, individuals in their lives, are influenced by personal beliefs and upbringing. These beliefs in some instances encourage health-seeking behaviours, while in other it hinders the health-seeking process. Furthermore, participants noted that knowledge of oneself further influenced health-seeking, as they believed that knowing their body well, which they knew better than others, would alert them to instances where they needed to seek health-care. As such, if they felt symptoms indicated abnormality they were more likely to receive health-care services quickly. This is supported by the Social Learning theory, which indicates that learning, personal beliefs and personality development is the mutual process of reciprocal determinism, whereby an individual learns social behaviour through a process of observing and imitating behaviour of their social environment (Cacioppo & Freberg, 2013:587; Chavis, 2011:472). Personality or social behaviour is further enforced through either a perceived reward to encourage the behaviour; or a punishment to deter the behaviour (Myers, 2013:363; Cacioppo & Freberg, 2013:587). As such individuals are likely to engage in imitated health-seeking behaviours from observations which were reinforced through rewards, for example a decrease in symptoms, or punishments such as worsening of symptoms.

Naledi: "Yeah, I think, also I've had quite a complex health over the past ten years, so I think because I know it can be so complex, I'm quicker to sort something out before it gets complex."

Kevin: "My immediate family they are quite well educated um so they share a similar point of view to mine I think. Where they kind of like to look at the facts first and get things sorted by medical professionals."

Quintin: "I look at my family and the way we have engaged with um the medical field if you would like. I feel, I feel like we have always erred on the side of caution."

Participants who have previously experienced more severe health problems indicated that they were now more likely to seek professional health-care services early, as they wanted to avoid health complications in the future. This finding differs to a finding by Friis et al. (2016:8), which found that among Danish individuals with long-term conditions there was a lack of understanding health related information and they were therefore less likely to engage in formal healthcare (Friis et al., 2016:8). This is further explained by reinforcement in the Social Learning theory, as individuals who have experienced severe symptoms are encouraged to engage in behaviour that will reduce symptom severity (Myers, 2013:363; Cacioppo & Freberg, 2013:587). Furthermore, if individuals perceive high severity in symptoms, they may feel the need to seek treatment after an evaluation of the possible consequences, as stated in the Health Belief model (Rosenstock, 1974:330).

Thandi: "Cause if you see, um, when somebody suddenly gets ill or dies, you realise how short life is and how important it is to look after yourself."

Mary: "I just would like to think I can survive comfortably till about 96."

Wyatt: I want to live a good life, I want to run around with my kids. Like I don't wanna have heart stints and be struggling with my hips."

Furthermore, participants are more likely to engage in active health-seeking behaviours if they have the desire to live long, healthy lives. What was reported by participants, is linked to the notion described by Bircher and Kuruvilla (2014:370), that all individuals have the common desire to live a long life. As such, individuals would be more likely to seek healthcare if they feel that this desire is threatened.

Melody: "When I was teaching like, you just keep going and you don't take a day off or whatever, but I think like now that I'm in ministry and it's like forever. So I don't have to like stick to sick days… Where before in teaching you just carry on. Cause you know that there's people depending on you… Where now I don't, I can reschedule meetings."

Wyatt: "when I was at work we had a, a doctor on site and a nurse on site. So I would always just go straight to the nurse"

A further individual factor reported by individuals is their lifestyles and what their day-to-day activities look like. Participants who had more time or easier access to professional healthcare services were more likely to engage in healthcare services than those who had more demanding lifestyles in terms of jobs or time. This finding is supported by a Yemen study conducted by Webair and Bin-Gouth (2013:1136), which found that individuals are more likely to use what is easily or readily available to them.

> *Mary: "I love my doctor."*
>
> *Amahle: "I've sussed out there which are the GP's that I trust and will go to. And um, which are GP's, if that's the only GP that's on duty, I will not go [to]."*
>
> *Wyatt: "I just enjoy competition and I enjoy sports and I enjoy being strong"*

Lastly, participants noted that personal preferences influenced health-seeking. Participants that reported using professional healthcare services indicated liking their doctor and having a level of trust. While other participants stated that they would avoid or discontinue healthcare services if it was a professional that they did not trust or felt uncomfortable with. Another participant indicated that personal traits such as enjoyment of physical activity or a competitive spirit increased certain positive health-seeking behaviours. Similarly a study by Deasy et al. (2014:85) in Ireland among university students, found that although aware of lifestyle choices that promote healthy behaviours and encourage healthy living, many individuals engaged in several behaviours that negatively impacted health. This can be supported by the Health Belief model, which indicates that in order for a person to engage in professional healthcare services, they would need to experience a health concern, which they feel susceptible to and they would need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences (Rosenstock et al., 1988:177). Thus, explaining why participants would be less likely to seek professional healthcare if they do not trust the healthcare professional, thus they would be more likely to seek alternative healthcare in these circumstances.

- ***Sub-theme 2.5: Spiritual factors***

The final sub-theme is representative of the spiritual factors that affect health-seeking behaviour. This sub-theme is directly linked to the factors of Charismatic Christianity that influence health-seeking behaviour and includes, spiritual practices, beliefs and rituals related to health and healthcare.

The following verbatim quotes from interviews support the fifth sub-theme:

> *Mary: "Yes, yes. I do yes" (b).*

Phillip: "Yeah, yeah, yeah". (b)

Kevin: "I don't think it really impacts it at all. I kind of … I don't necessarily see my religion and faith linked with my health." (a).

Quintin: "It doesn't. It's purely based on what I feel and what I feel is the best course of action based on what I am feeling." (a).

As was noted by Mishra et al. (2017:1283) spirituality influences life decisions, actions and personality, thus, it was expected that spirituality would be a factor influencing health-seeking behaviour of Charismatic Christians. Throughout the interview process, it became clear that participants were affected in three main pathways regarding their spirituality and health-seeking behaviour. Although all participants indicated that spiritual factors influenced their health-seeking behaviour, when asked the questions a) "have you found that Charismatic Christianity has influenced your decision to seek or receive healthcare" and b) "would you let spirituality guide you when someone is sick", participants responded with mixed responses. While some believed that their spirituality influenced their decision making, others denied there being any influence.

Thandi: "God also created us with brains. So if you see a doctor and the doctor can treat you, let the doctor treat you".

Melody: "I feel like you know, God created people to, he created medicine, he wants us to seek help so like, if you need medication for depression you, you should go see someone. So I really believe that, yeah, that there's, like there's place for prayer and trusting for healing but then there's also place to go and see the right doctor, the right specialist."

Kevin: "If there is something that I am concerned about I will pray about it but at the end of the day I feel like it's just for my own peace of mind."

Quintin: "In Christianity it is believed that your once you are sick should you pray to God and have enough faith that you will be healed but I'm of the opinion that even doctors and the medical field is God given so seeking help is the same thing for me. So it doesn't influence me in any way. For me I view it as part of um God's kingdom."

Amahle: "I speak Philippians 4v8 out loud, which is the peace of God, which we cannot understand or change the way I think or feel. And when I say that um, it, it really helps me in um, in combating the anxiety."

The first pathway was that spirituality did not directly influence health-seeking behaviour, but that it provided a form of support, comfort and a source of strength when faced with illness. As such, individuals experienced an emotional benefit but sought healthcare without influence of their spiritual beliefs. Similar results were found in study conducted by Hilbers et al. (2010:5) in Australia, which found that 80% of respondents stated that spirituality impacted their health-seeking behaviour and healing. This can be further explained by the Health Belief model which

indicates that health behaviours would be more prevalent if an individual experiences rewards with few consequences. As such, participants are likely to engage in spiritual practices and professional healthcare services as it provides comfort, support and relief of symptoms, thus providing increased rewards with few consequences (Carpenter, 2010:4). Respondents attributed this to the fact that spirituality provides support and increased positivity. The participants in the current study appeared more likely to seek healthcare as they are of the belief that modern medicine was created by God, and individuals should therefore use their autonomy and access these services when needed. However, it is important to note that this group of participants do not dispute the occurrence of miracles.

> *Phillip: "I think it is understanding that God has created me in this body and that therefore he has entrusted me to look after it, so I do think that um, understanding that and understanding who God is and wants me to be and that he does want me to look after myself and therefore, to avoid things and to do certain things, like exercise, um and you know, eat healthy… I also I feel that I need to embrace without also damaging myself. So enjoy what is there to enjoy as long as it, it falls within the bounds of what God deems as good for me."*

The second pathway identified, was that spirituality provided participants with certain values and teachings that encouraged them to live healthier lifestyles, as such, this was seen as encouraging positive health-seeking behaviours. As previously stated, the Social Learning theory, theorises that through the process of socialisation, individuals will observe and imitate the behaviours around them (Pratt et al., 2010:768). As such, individuals in the Charismatic Christian community are likely to observe and imitate the behaviour of other Charismatic Christians, which was influenced by Charismatic Christian teachings. Similar results were found in the Australian study by Hilbers et al. (2010:5), which found that spirituality impacted health-seeking behaviour as it provided a framework for healthy living as discouraged risky behaviour by classifying some behaviours as a divine sin, which will be punished. Similar results were found in review by Koenig (2012:8-9) of previous studies which found that in over 100 studies individuals with higher spirituality were less likely to smoke cigarettes, in over 20 studies spiritual individuals were more likely to partake in moderate exercise and healthier diets and in over 90 studies, highly spiritual individuals were found to be less likely to engage in risky sexual behaviour.

> *Naledi: "I think it influences my dad a lot, um he, when my mom was terminally ill, he believed that if you prayed God would heal her… He believed that his prayer was stronger than any scan than or any doctors results."*
>
> *Mary: I believe in Jesus and Jesus when he walked the earth, healed everyone. And somehow we've fallen very far from that. And although I, I'm careful not to say*

I'll never use medicine again, I still seek that kind of healing. That you could speak to yourself or speak to others and recover."

Claudia: "I would take longer [to receive healthcare] because I believe that, that God would do it for me."

Lastly, some of these teachings provided participants with the belief that God would provide healing, as such professional healthcare services were not necessarily needed. As a result of this individuals experienced negative effects regarding their health-seeking behaviour, as they would prolong illnesses by delaying seeking professional healthcare and in some instances would discontinue or not adhere to treatment methods provided by healthcare professionals. Similar results were found in a study conducted in Ghana by Kretchy et al. (2013:5) that found that individuals with high spiritual beliefs were less likely to adhere to treatment methods. As they were more likely to experience peace and place trust in divine healing and traditional medication. Similarly, in a study conducted in Pakistan by Anwar et al. (2015:292), it was found that in the Muslim belief the Quran holds 'Verses of cure' which are used for treating illnesses, although individuals are not discouraged from seeking formal healthcare, the belief remains that Allah is the divine entity that will provide the cure. In the Health Belief model it is stated that in order for a person to choose a specific health behaviour, they would need to experience a health concern, which they feel susceptible to and they would need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences (Rosenstock et al., 1988:177). However in the case of Charismatic Christians, if they perceive God as a being that will eliminate health threats with few consequences, they are more likely to rely on God for healing than seeking professional healthcare services.

3.7.2.3. Theme 3: The value, beliefs and practices of Charismatic Christianity

The third theme pertained to Charismatic Christianity, more specifically, the values, beliefs and practices of spirituality and their effect on the health-seeking behaviour of participants. To more clearly discuss the theme, theme 3 has been sub-divided into four sub-themes, which will be discussed in detail with reference to both verbatim quotes as well as linkages to previous studies. The sub-themes include, church practices, biblical and pastoral teachings; spiritual grounding, comfort and guidance; miracles and healing versus medical intervention; and the presence of spiritual attacks and the disregarding of physical and mental illnesses.

- ***Sub-theme 3.1: Church practices, biblical and pastoral teachings***

The first sub-theme defines how participants describe Charismatic Christianity in terms of their common church practices and rituals as well as their important teachings derived from the Holy Bible and through teachings by the pastor of the church.

The following verbatim quotes from interviews support the first sub-theme:

> *Mary: "Total dedication, and also um, enjoying life. You know just uh, with God. Bringing the relationship with a higher person or being, into my life, the three- God, the son, the spirit.*
>
> *Naledi: "Spirituality I think is having God within you and it can also be a spiritual moment though, it depends in which context. But um yeah, just being spiritual is having God in your life."*
>
> *Phillip: "God has a spiritual relationship with me and I and that flows into all areas of my life, both the physical, the mental… Spirituality is the journey I suppose that, that I am on, within, within myself and what I believe in the things that I'm not seeing I suppose, specifically God."*
>
> *Quintin: "Spirituality um I guess is your connection to your – or your belief in the higher being. And so you try follow certain um religious and cultural norms that are prescribed to you."*

Charismatic Christianity, as described by participants is the daily dedication of your life to the Father, the Son and the Holy Spirit. It is further characterised as the conscious effort to develop a relationship with God, as a higher being and the belief in God despite not being able to have a physical relationship, thus using faith to believe in a higher being that is not physically visible. As such, participants defined spirituality, in relation to Charismatic Christianity similarly to Dein and Cook (2015:98). They described Charismatic Christianity as the belief in the trinity (God, Jesus and the Holy Spirit), by accepting the Bible as the word of God, the belief that Jesus Christ is savior and by placing emphasis on the importance of the Holy Spirit.

> *Mary: "Church going on a Sunday- if its open. Um, praying together with others, um and then having a quiet times."*
>
> *Melody: "So church, going to church… We have a life group, like a bible study group on a Wednesday night, which is not really a bible study, it's more like, yeah you get together and talk about different topics."*
>
> *Phillip: "Number one is prayer is a massive big part of my spiritual walk. Um, spending time with God and, and just hearing from him and the Holy Spirit, what he wants from my life. Um, number two, um would be going to church um and communing with other people that are, that have the same faith as me."*

> *Wyatt: "I pray often, um, worshipping as, as an event like in church but then also worshipping in my daily lifestyle… How can the work I do in the corporate world be submitted as a form of worship to God. Um, fasting as well."*

The typical practices that participants, as Charismatic Christians, partake in is attending church services; prayer as individuals or in groups; "quiet time" or devotional time where individuals read scripture and develop their relationship with God, they can also use this time to participate in religious practices such as fasting ; studying scripture and teachings as individuals or as a group, participating in praise and worship; and lastly, devoting your life to God usually through the process of Baptism. Interestingly, the core beliefs of Charismatic Christianity as described by Asamoah (2016:1643) were rarely discussed by participants. The core beliefs included miracles and healing, speaking in tongues (glossolalia), spiritual growth and prophecy (Asamoah, 2016:1643). Of the core beliefs only miracles were discussed by participants, which will be discussed in detail in the following sections.

> *Amahle: "I'm very quick to stand up in a congregation while a service is going on to say I do not agree with what you are saying and leave… I love research and facts. Um, a previous church that I attended, there was a Reverend who had his Doctorate in Theology and I loved having, um, our conversations with him about um, biblical facts and the different viewpoints."*
>
> *Thandi: "In all honesty, I sometimes attend them [church services] because I have to be there and I don't really feel like being there."*
>
> *Thandi: "Super spiritually, Christian, "Chistian-eese", you know what I mean? It's like you know…I mean I, I believe in God. I'm a Christian. I was saved, I've been water baptised. But there are still some things that I would not participate in conversation because I know that certain people are… can I say over the top? It's…I guess I question there's certain things in the Bible that I question."*
>
> *Wyatt: "I feel that maybe if we have certain religious practices we might practice them for the sake of practicing them."*
>
> *Kevin: "For me it is difficult. I do consider myself a Christian – I do believe in God but I don't like religion. I think the premise of religion is broken and it's been overtaken by the greed of man for his own personal gain."*

There appears to be a movement of participants away from traditional church, they state that they are increasingly researching Charismatic Christianity and have started to challenge church belief systems, especially in the case of ambiguity in the Bible. Furthermore, it appears that some participants engage in practices as is expected of Charismatic Christians and not because they feel the desire to. This however, does not mean that participants no longer believe in, or feel a connection with God. This behaviour can be explained through Social Learning theory which indicates that individuals observe and imitate behaviour of those around them, especially if there

are few consequences. As such, individuals would be likely to imitate practices as they are expectations with few consequences, rather than imitating behaviour out of a desire to (Myers, 2013:363; Cacioppo & Freberg, 2013:587). This may further be explained by Anderson's (2013:4) findings stating that Charismatic Christianity is adaptable and flexible. Thus it has been able to grow and adapt to changes in modern times and in various cultural groups (Anderson, 2013:4). As such, it is possible that participants are being influenced by the a time that is characterised by wanting to gain knowledge and access to knowledge, thus wanting to be more involved in actively learning the teachings regarding Charismatic Christianity.

> *Naledi: "I think a lot of the principles they teach you is that they, they want you to be in control of your life and want you to live with margin and to be in control of your budget and… so a lot of the, the, the things they try and teach you, filters through into mental health…looking after yourself is the same as looking after your finances in that context. Like leaving space for yourself, taking care of yourself, making sure you have battery left- over, self-care".*
>
> *Wyatt: "I do believe that my body is a temple and that I am to take care of it… I think fasting also affects my health-seeking behaviour because when you fast you, in a way you audit your life… "What is it in my life currently that isn't actually serving me very well. That number one, not necessarily my physical health but what 's having an effect on my mental health?"*
>
> *Wyatt: "The story of the good Samaritan, where the Samaritan walked past the guy who was beaten up on the road and he took him and he nursed him, he didn't stop and pray for him to be healed, like he took him and he nursed him."*
>
> *Amahle: "Some people can almost see God as like a Genie in a bottle that you can just magically make things better and I believe that he, he uses tools cause even if you look at when Jesus was on Earth in the Bible and a blind man asked him "please heal my sight" he didn't just say "Okay well it's done". He spat in the ground and mixed mud, it, it was a type of medicine I believe that he put on the guys eyes."*

Participants indicated that there are several principles from Charismatic Christianity teachings that affect their approach towards health-seeking behaviour. Firstly, living in margin as it teaches control which effectively benefits mental health. A second belief affecting health, is the belief that the body is a temple of God, as such it should be treated with respect, which in turn decreases harmful behaviours while increasing health promotion behaviours. Linked with this is the concept of fasting, as fasting can be seen as a health-seeking behaviour, as it temporarily rids the body or mind of harmful behaviours that were interfering with an individual's relationship with God. Lastly, some participants believe that teachings of the Bible show Jesus using rudimentary medicine for healing and parables that encourage helping others heal, thus healthcare practices can be seen as biblical in nature."

The Social Learning theory indicates that individuals' behaviour will be enforced by reinforcement, either by rewarding a particular wanted outcome or by discouraging behaviour through consequences, known as differential reinforcement (Pratt et al., 2010:768). Differential reinforcement is the balance between expected rewards and anticipated consequences. A reward is likely to lead to repetitive behaviour whereas a negative consequence is expected to deter behaviour (Pratt et al., 2010:768). As such, Charismatic Christians are more likely to engage in behaviours from their teachings that either lead to rewards or to avoid consequences of risky behaviour.

- ***Sub-theme 3.2: Spiritual grounding, comfort and guidance***

The second sub-theme was created to discuss the influence of Charismatic Christianity, in terms of the ability to provide spiritual grounding, comfort and guidance in times of stress and turmoil.

The following verbatim quotes from interviews support the second sub-theme:

> *Naledi: "It gives you a good grounding because um, it's easy to, for one bad decision to lead into many others so, I think it just keeps you grounded and connected to something."*
>
> *Quintin: "Well it adds value in that it, it keeps me grounded from a moral perspective."*
>
> *Wyatt: "I think it, it really grounds you and it reminds you about what is important."*

Participants responded that Charismatic Christianity provides them with spiritual grounding that in turn helps them make good decisions, thus, limiting risky behaviours and leading to more healthy lifestyles. Similar results were found in a study conducted by Hilbers et al. (2010:5) in Australia, which found that spirituality provides support, it increases positivity and it provides a framework of how to live a healthy lifestyle and avoid risky behaviour, thus having positive impacts on health and increasing positive health-seeking behaviours. This can also be described by the Social Learning theory that provides that individuals have expectancies about environmental outcomes, meaning that a particular behaviour will only be performed when, the person understands what event their action will lead to, the consequences of their personal actions and whether they have the competence to accurately perform this type of behaviour (Williams, 2010:1). As such, Charismatic Christian teachings provide individuals expectancies of certain behaviours, thus allowing individuals to make informed decisions regarding their health-related behaviours.

Participants reported that Charismatic Christianity provides support and comfort in various ways. This was expected as Koenig (2012:7) reported in a review that spirituality can influence mental health, as it provides coping mechanisms and reduces the likelihood that stress will result in severe emotional disturbances resulting in disorders. This happens due to the fact that spiritual beliefs are able to give meaning or purpose to events and the belief that a powerful being will provide for their personal needs (Koenig, 2012:7). In conjunction with Koenig's (2012:7) discussion, participants indicated that comfort and support were provided through both God and community as discussed below. Comfort and support are seen as rewards, thus according to the Health Belief model and the Social Learning theory, individuals are likely to engage in spiritual practices concerning health as it provides rewards (Myers, 2013:363; Cacioppo & Freberg, 2013:587; Carpenter, 2010:4).

> *Mary: "I'm a great prayer. So I believe in God and that I have great, great peace and joy in praying. And I do pray a lot. Um, but I just, I can actually even destress myself by praying."*
>
> *Melody: "If it wasn't for my spirituality I wouldn't overcome the things that I have. Like I didn't have the best family life… I think becoming a Christian, like I had to really rely on God to heal those past hurts to, to bring me to a place of wholeness. So I think, yeah, like it's so interlinked in who I am. If it wasn't for my spirituality then I'd probably still be quite a broken person."*
>
> *Kevin: "Well for me when it comes down to dealing with something that is bigger than myself so for example um my father was recently quite sick and obviously I can do nothing about that, so praying and that just helped me feel like I was able to do something."*
>
> *Quintin: "In tough times it gives you what I would say the mental steel to push through those tough times knowing that you know you have a higher being looking over you… Just knowing that there is a God who looks out for you and loves you as much as He loves any other human being is obviously something that um is heart-warming and you know keeps you, keeps you going."*
>
> *Quintin: "We pray about it and usually from that prayer we are I guess emboldened to face whatever truths may come out from whatever tests may need to be done or whatever consultation with a doctor so prayer definitely – I feel like prayer is more what gives us the courage to go and do it even when you may suspect that the news won't be great."*

Firstly, through God and the process of prayer and scripture, participants find scripture and prayer to be a source of encouragement and guidance, thus increasing their coping capacity and decreasing their feeling of stress. Participants further describe a relationship with God as having the ability to heal their emotional pain, thus further strengthening mental health. Furthermore, prayer provided participants with a feeling of comfort in healthcare, as they felt like they were able to do something, even though the situation was out of their control, thus providing a level of peace

and purpose. This indicates that the practices of prayer and reading scripture provides rewards to individuals, thus according to the Health Belief model and the Social Learning theory, individuals are likely to engage in spiritual practices concerning health as it provides rewards (Myers, 2013:363; Cacioppo & Freberg, 2013:587; Carpenter, 2010:4). Similar results were found in a study conducted by Hilbers et al., (2010:5) in Australia, which found that 80% of respondents stated that spirituality impacted their health-seeking behaviour and healing, they attributed this to the fact that spirituality provides support, it increases positivity and it provides a framework of how to live a healthy lifestyle. Furthermore a review by Koenig (2012:7) found that spirituality can influence mental health, as it provides coping mechanisms and reduces the likelihood that stress will result in severe emotional disturbances resulting in disorders.

> *Naledi: "I think it really helped me connect with good friends and it's like a common base that you can always talk about and relate to each other."*
>
> *Mary: "I have a little group to they both would say listen you better just go cause if you keep complaining, stop it now, go get it checked out."*
>
> *Melody: "In church life you can find spiritual mothers and fathers that can parent you in a way that your parents maybe never did and affirm you in a way that your parents never did and I feel in a way that, that can only happen in community."*
>
> *Kevin: "I think also knowing that people out there when you are going through a tough time have you on their mind and they will pray for you or whatever – maybe it's just that added support or added peace of mind."*
>
> *Wyatt: "I have an accountability group um, that we, so at Church we ran this thing, called The Conquer Series, it's about like conquering sexual temptation and the pornography addiction that no one really talks about. So we have an accountability group that came of that."*

Secondly, the church provided a support structure in terms of the church community. As participants are feeling support and comfort, they are securing friendships and a community which contribute towards increased mental health capacity. Furthermore, support within the community provided participants with people that encouraged them to seek healthcare when they felt there was need for concern. As such, it can be seen that Charismatic Christian communities increase health-seeking behaviour through advice, concern and encouragement. According to the social Learning theory, this church community would act as a framework where individuals would observe and imitate behaviour, especially as there is a level of trust and being part of the community provides rewards (Myers, 2013:363; Cacioppo & Freberg, 2013:587).

> *Quintin: "You pray that you know the doctor can find whatever is wrong with you or you pray that whatever is going on with you isn't serious."*

Amahle: "Especially if I don't know what's wrong. Please guide the doctors to make the correct diagnosis." [Through prayer]

Lastly, participants describe Charismatic Christianity as being a source of guidance both individually and within the community. Specifically related to healthcare, participants describe guidance through prayer both in how they should seek help and in the treatment methods of healthcare professionals. Thus, they feel more comfortable utilising healthcare services as they believe that God is guiding the process. This is in contrast to a study conducted in Ghana by Kretchy et al. (2013:5) which found that individuals with high spiritual beliefs were less likely to adhere to treatment methods due to experiencing peace and placing trust in divine healing. However, participants in this research study found that although they experienced peace and trust in God, they relied on God for his guidance in the health-seeking process, as such, they did utilise healthcare services.

- ***Sub-theme 3.3: Miracles and healing versus medical intervention***

The third sub-theme is defined by the participants through their discussion of the presence of healing miracle versus the belief and trust in medical intervention; and the combination thereof.

The following verbatim quotes from interviews support the third sub-theme:

Mary: "I believe I was healed when I had my last op [operation]. I had an experience in the night and I thought… and they said no don't worry it's just the stronger morphine. Don't worry, you know, it's just the morphine, you're on a high. I said no I'm healed."

Phillip: I think there've been times where maybe I've really hurt myself or done something and my wife has prayed for me. And to get better."

Kevin: "I have seen miracles if you want to use that word in my family with like, so my father again he's um he's got renal failure so he is quite sick um and there has been more than once where if not for an external force he probably would have been 6 feet under by now so there is definitely been like signs of ok that was we got away with something there."

Amahle: "Because um, after I've prayed um, the, I, I really was reluctant to go back on anti-depressants because it's been such a long battle and I was incredibly depressed and um, through that, with um, through prayer- one morning I woke up and it was gone completely."

All the participants made reference to divine healing through miracles. Participants were able to provide testimonies of the miracles of God, either through personal experience or from friends and family. Participants reported that prayer was usually the method used when seeking intervention from God. This was similar to what was discussed by Cartledge (2013:519), who

stated that miracles ensured the healing process through prayer which can be done by various role players, including: the family members of the ill individual, prayer partners and the church leader. This would be especially apparent through the process of direct experience, as discussed in the Social Learning theory, where individuals learn that certain responses result in favourable outcomes, while other responses may lead to less favourable or undesired outcomes (Bandura, 1971:3). As such, if prayer has previously resulted in healing, individuals would view this as a favourable outcome and therefore engage in this process again.

> *Thandi: I've recently heard a testimony of someone where a doctor…said this is the situation with your unborn baby you can terminate and they said absolutely no ways. Prayed and prayed… and even the doctor in the end, after doing all the tests said "wow that was a miracle" and they said "Yes we know, cause we prayed"."*
>
> *Naledi: "Yeah, so I lost my mom. She did receive healthcare, I mean she didn't not um, but, even though it had spread all over, he [father] believed that God would heal her. He believed that his prayer was stronger than any scan than or any doctors results."*
>
> *Kevin: "For example my grandmother she is very much about prayer right now. She will pray for two weeks about something rather than go to the doctor."*
>
> *Quintin: "My father had renal failure – um about a decade and a half ago and at the same time he found God and he prayed for his recovery and he truly believes and I am of the same opinion that he was healed by God and he decided to stop doing his dialysis treatment… I feel like he has grown distrustful of doctors in general and the medical field to an extent."*

The belief in miracles, at times resulted in individuals refusing healthcare or not adhering to treatment plans, therefore, negatively affecting health-seeking behaviour. Furthermore, some participants referred to instances where their belief in God's healing powers was greater than their belief in healthcare services. For one participant, it was reported that because God allowed a miracle, there is now distrust regarding healthcare services, as God provided what healthcare could not. This resulting in healthcare services being sought less often. This coincides with what was discussed by Cartledge (2013:519) who stated that individuals who believe in miracles were willing to agree that illnesses can derive from a biological or environmental nature, however, they believed that the power and love of God is able to cure all illnesses, therefore allopathic medicine is not necessary. However, as will be discussed, most participants valued healthcare services but participants above 60 and participants with older parents or grandparent, appeared to behave more in the manner discussed by Cartledge (2013:519). Similarly to this the Health Belief model indicates that barriers, such as ineffective treatment plans are likely to lead to individuals

disregarding professional healthcare services, whereby benefits, such as a belief in God leading to miracles would be more likely to increase this type of behaviour (Carpenter, 2010:4).

> *Thandi: "So yeah definitely both [prayer and healthcare]. Just use your brain, if you know that you're not well and you know, you know, that you're not in a good place, then seek help."*
>
> *Naledi: "I'd more just more say just prayer because I definitely believe in medical intervention."*
>
> *Mary: So my spirituality does run my health. But there are times when I do have to humble myself and take the pills.*
>
> *Phillip: "Personally, I will, I will do both the spiritual side as well as then go see a doctor. I think that if you, I won't just pray that I will miraculously get better. Um, I do but that's not the only thing I do, I will then also then go and, and seek a doctor, get the medicine that is there and then go from there."*
>
> *Quintin: "In Christianity it is believed that your once you are sick should you pray to God and have enough faith that you will be healed but I'm of the opinion that even doctors and the medical field is God given so seeking help is the same thing for me."*

Despite believing in miracles, several participants still noted that they believe God created professional healthcare, as such it should be utilised by them. Some participants noted that medicine in itself was created by God or were of the mind that healthcare could be sought while still having faith that God will provide a miracle. As such these participants were more likely to utilise healthcare services.

> *Naledi: "When my mom was terminally ill, he [father] believed that if you prayed God would heal her. So that, it influenced his ability to like decipher reality from, from what it is or isn't."*
>
> *Kevin: "I think that um if something serious enough to pray for in terms of cancer, kidney disease – whatever the real big things. They are not – I don't believe necessarily that they are in God's hands per se. I believe that it was going to be that way anyway but for some people it is hard to understand that and when their miracle prayer isn't answered it does leave them with a lot of questions and negative feelings."*
>
> *Wyatt: "I, to be honest, that's something I've struggled with cause uh, my grandmother passed away from cancer. Um and we prayed. Um, and then four years later my sister passed away from cancer and Lord knows I prayed for that… but I think it was like the adverse effect, where what happened affected my, cause after my sister died, man I, I struggled to, to pray you know? I struggled to, to connect with God and I remember at church, there was this song, the lyrics go- It's your breath in our lungs so we pour out our praise- and I was like, I couldn't sing that you know? Cause when my sister died, I, she had cardiac arrest and she couldn't breathe and I was like I can't sing that. Like, you know? Um, but slowly but surely I found my way back."*

Wyatt: "I think that um, something that maybe isn't discussed is when for example, someone prays for break-through or prays for a miracle or prays for healing and that doesn't happen. There, there's a very- a form of cognitive dissonance that goes on because you can speak and be like "you know I believe that God will do this da da da" but on the inside you're carrying this disappointment and that doubt and I think that causes so much inner turmoil that isn't really addressed."

Kevin: "My grandmother believes like fully that God can help you with anything um and if you don't get helped with something then it's because of something that like you've done wrong, or your parents have done wrong in the past… Again, like my grandmother or grandparents she definitely is impacted by it in terms of its either her fault or she didn't pray hard enough or something like that if something happens to someone she loves."

Participants reported that although they believed in miracles, there were times that they lost faith or were disappointed with the outcome, as no miracle was experienced. Participants noted that at times, this belief in miracles was so great that individuals were not able to rationalise and accept what the circumstances were in reality. It was noted that this disappointment was not often addressed and caused emotional distress for individuals, thus having a negative impact on their mental health. As discussed above in the Social Learning theory, through the process of direct experience, individuals will learn that certain responses result in favourable outcomes, while other responses may lead to less favourable or undesired outcomes (Bandura, 1971:3). As such, in the cases where prayer did not result in a miracle, spiritual practices would not have led to favourable outcomes, thus individuals may feel despondent or lose faith, therefore, not repeating the behaviour. These results corresponded with results from a Belgium study conducted by Arrey et al. (2016:4), which found that individuals who believed that they had been abandoned by God, were impacted negatively. In some cases, individuals may attribute this lack of a miracle as a personal failure and attribute it to factors such as, not being a good enough Christian or not praying hard enough. This would further impact their mental health, as individuals would view their efforts as failures.

- ***Sub-theme 3.4: The presence of spiritual attacks and the disregarding of physical and mental illnesses***

The final sub-theme was related to how participants mentioned the belief in spiritual attacks as a possible cause of illness and the disregard of mental and physical illnesses due to the belief in divine healing.

The following verbatim quotes from interviews support the fourth sub-theme:

Naledi: "When my brother got shot, um, he believed [father], so the bullet went into his brain and it didn't come back out, so all his brains were jumbled up, um, so

> *they said we can operate to take the bullet out but he will be a vegetable… After my brother's death he said that, he believed that the um, the only reason why my brother got killed is because um, my brother was becoming a true Christian and the devil saw what a good person he is, my brother was and that's why he got killed."*
>
> *Melody: "I think you do get Christians that are like, there's no such thing as like depression and things like that… *Peters [husband] dad and like the depression thing he's like it's a, it's like totally in the mind it's not like I think that he would admit that it's like a illness."*
>
> *Wyatt: "I've come across maybe some older generation people, older generation Christians who say that psychology is from the devil. Because they believe that every single mental health issue is a demon and therefore they wouldn't go to a psychologist."*

Several participants attributed illnesses to spiritual attacks rather than biological factors. Although not all participants believed this themselves, they were aware of other Charismatic Christians that held these beliefs- these were usually older family members. As such, these persons would be at an increased risk of not seeking professional healthcare, as they would believe that healing would occur through deliverance from God. As discussed in the Social Learning theory, reinforcement provides meaningful information regarding behaviour and consequences. An individual is able to receive meaningful information regarding the consequences that accompany behaviour, through the process of observation. The observed consequences can facilitate the creation of hypotheses that are most likely going to result in favourable outcomes for an individual (Bandura, 1971:3). As such, if an individual believes in spiritual attacks, either through observation or direct experience, they are more likely to engage in behaviour that they are taught will result in deliverance.

This further highlights research of Mercer (2013:598) and Asamoah (2016:1646) who state that those who believe in deliverance, state that all illnesses or life challenges are due to the interference of demons in an individual's life, or they are servants to Satan. In these cases, expulsion of demons will end suffering, therefore allopathic medicine will not be able to cure illnesses (Asamoah, 2016:1646; Mercer, 2013:598). As such, it would be expected that these individuals will be less likely to seek medical intervention if they believe that the illness is a spiritual attack. Similar results were found in a study by Abubakar et al. (2013:4), conducted in Kenya, which found that individuals who believed that the illness derived from biological mechanisms, would seek formal healthcare services. However, if illnesses were believed to be a form of mental illness, then traditional healers or spiritual elders were more likely to be consulted.

3.7.2.4. Theme 4: Social work in the healthcare setting

The final theme of the research study regarded social work in healthcare settings. This was further divided into two sub-themes namely, the lack of interaction with and knowledge regarding social workers in health-care settings; and the potential role of social workers in integrating health and spirituality in healthcare settings.

- ***Sub-theme 4.1: The lack of interaction with and knowledge regarding social workers in healthcare settings***

The first sub-theme highlighted that there was a lack of interaction with and knowledge regarding the role of social workers in health-care settings by participants. The following verbatim quotes from interviews support the first sub-theme:

> *Naledi: "Well my, my friend's friend is adopting a girl but I mean that's very far."*
>
> *Mary: "Not mine [healthcare], with the children, with the children at Oasis [Child and Youth Care Centre] but not mine."*
>
> *Phillip: "Not specifically [had contact with a social worker], but I'm sure, I'm sure there has been people within, yeah um, my family um, I think, I think my sister-in-law has, has um more to do with, um mental things that she herself or some um of my family members were going through. And I'm sure there've been guys in the church that have had access to social workers."*
>
> *Claudia: "For myself? No but maybe I should have [had contact with a social worker]. Uh, uh no for me."*
>
> *Kevin: "Uh again my father I know that he was asked to speak to I think it was a social worker or psychologist or something like that and maybe his family so I guess it would be us but I don't think that ever happened."*
>
> *Wyatt: "I won't lie, I don't know exactly what a social worker does these days."*

Participants responded that they had never had contact with a social worker regarding healthcare, nor had they heard of family or friends being in contact with a social worker. This was surprising, as several participants and their families had experienced serious health concerns such as cancer, renal failure and traumatic deaths. Despite this, two participants indicated possibly knowing someone who had contact with a social worker in healthcare, but were unsure of the extent of contact entailed. With regards to the Social Learning theory, this was expected due to the fact that individuals expressed limited contact with social workers within their families. As such, the benefit of social work services in healthcare was not observed, therefore it was not imitated. Furthermore, as participants had not had direct experience with social workers, they would not have experienced any rewards from seeking these services, thus behaviour would not be internalised (Pratt et al., 2010:768; Bandura, 1971:5).

Furthermore, this lack of contact with social workers led to participants not understanding the role of social workers in healthcare. Participants appear to only briefly understand the role of a social worker in adoption and working with vulnerable children. Despite this, several participants indicated that they would like to have contact with a healthcare social worker in the future and believe that social workers could integrate healthcare and spirituality as discussed in the following section. This was an unexpected finding, as social workers often form part of a multi-disciplinary team to provide holistic care for patients and are involved in providing individual, couple, group and family counselling, crisis intervention, patient/family education, resource referral and advocacy, all common in healthcare settings (Jalil et al., 2012:1).

- ***Sub-theme 4.2: The potential role of social workers in integrating health and spirituality in healthcare settings***

The final sub-theme highlights the potential role of social workers in health-care settings, in terms of integrating healthcare practices with spirituality, as described by participants. The following verbatim quotes from interviews support the final sub-theme:

> *Thandi: "I think there is, there's a place for that yes… If you're going into hospital and you're filling out a form, I don't know how much of those the doctor reads. But I think it is important if that person would read "Okay this person is a Christian"."*
>
> *Naledi: "I think in general, not a lot of emphasis is put on um, spirituality and I feel like it, it, it can bring a lot of healing. It can, yeah. It can do a lot for you. And it's sort of never mentioned by anyone."*
>
> *Phillip: "I think it is important that, that, social workers, doctors or whatever, anyone, um, in the medical field can, I think it is important for them to find what is, what is a person's spiritual belief is and, and work with them, within their spiritual belief to both help them achieve the desired outcome of good health, using their faith. So understanding what their faith is and what their restrictions are and what they can and cannot do I think will be important in, yeah, in developing a plan that will make them healthy in a way."*
>
> *Claudia: "I don't think we have it in like our consent forms and I really haven't seen it. But in the consent space you know, um, especially if you're going to a hospital, you know they ask you, you know have you had allergies to medication, what medication do you take? So um, and I think there's still like, like I don't know if it's still there, like a space that says like, if someone wants to pray with you."*

Most participants noted that they believed that social workers could have a role in the healthcare multi-disciplinary team to help integrate healthcare and spirituality. Especially as social workers have a unique role of advocating for the rights and needs of individuals and a professional standing in the multi-disciplinary team, therefore, they are afforded the opportunity to communicate the spiritual needs of individuals to the multi-disciplinary team (Craig & Muskat,

2013:11). In conjunction with this, participants indicated that they would want this service and felt that it could be beneficial for Charismatic Christians as a whole and could be used as part of the healing process. However, a few participants felt that this would be unnecessary and would not accommodate them in their healing process. Similar results were found in a study in Australia, conducted by Hilbers et al. (2010:6), that found that over 70% of individuals wanted a team member to ask about their spirituality. They believed that this would facilitate a healthy relationship between medical staff and patients. In contrast to this 10% of respondents indicated that staff should not enquire about their spirituality. As such, according to the Social Learning theory, if social workers in healthcare settings begin to have increased contact with Charismatic Christians, thus enabling them to experience the benefits of these services, individuals would be more likely to imitate this behaviour in future settings (Pratt et al., 2010:768; Bandura, 1971:5).

> *Melody: "Then I think maybe a social worker would have to be more cautious with, cause I think Charismatic Christians such a broad like spectrum of people, you do get people that are so conservative and so like pray first before medication, so I think like those kind of people a social worker would need to like, it would be hard to try and convince them."*
>
> *Naledi: "You just need to be so aware of what can cause offence."*
>
> *Mary: "But it is such a relational thing, because obviously I'm not accepting the um, the medical professionals professionalism sometimes. Sometimes I'm saying "no please wait" you know? Don't but I, but I, as long as, to me the value of the person is his choice. So as long as you give that person a choice… So you need to listen carefully and advise them. And hopefully lead them to the right decision but it's still their decision."*
>
> *Amahle: "The only thing I would say is you can't um, force your um, specific ideas on, on a person, from… and, and the social worker from your whatever religious beliefs… I believe it's your job as a social worker to give me all my options from a very um, detached- is detached the right word- detached way, regardless of what your opinion is about that… If you do know the religion it can help you maybe just be more, more sensitive towards what you say."*

Participants indicated certain values that social workers would need to achieve this role of integration. Firstly, social workers would need to have knowledge of Charismatic Christians and their beliefs and realise that this is a broad spectrum, meaning that not all can be treated alike and should be attended to on a case-by-case basis. Secondly, due to the beliefs of Charismatic Christians social workers may need to engage in religious practices, especially prayer, as some individuals may find this as a necessary component in the treatment plan. Thirdly, social workers would need to have a non-judgemental and accepting attitude to create rapport, trust and support and avoid causing offence or withdrawal. In an Australian study, by Hilbers et al. (2010:6), it was found that respondents would find sharing their religion beneficial if staff were able to remain non-

judgmental and culturally sensitive or if they were severely ill. Furthermore, social workers should avoid transferring their own beliefs onto the patient. Lastly, it is important for social workers to remember that all individuals have autonomy and their choices should be respected, therefore social workers should work with the patient and the multi-disciplinary team to find treatment methods that patients are comfortable with. Participants requested similar values from social workers as is described in social work theory namely, the social worker must remain culturally sensitive, non-judgmental and avoid placing their own beliefs on the client, as clients should be awarded the right to express self-determination and be involved in decision making (Ferreira & Ferreira, 2015:503). As such, these suggestions by participants would increase the rewards experienced by individuals when receiving social work services and decrease consequences, therefore making engagement in these services more likely, as discussed in the Health Belief model (Carpenter, 2010:4).

> *Kevin: "I think it's more about knowing how I am with my religion like it would really irritate me if my social worker was like don't worry I prayed everything is going to be all right cause like don't lie to me like that. So I think it's more understanding how I feel about my religion… Knowing that um yes we've prayed – we've done what we can and I'm here to support you rather than being don't worry we've prayed it's all been sorted."*
>
> *Wyatt: "I could say I draw my strength from my faith but I might not actually be drawing my strength from my faith and as a social worker it's not, you not necessarily, you're not a pastor so you don't need to strengthen their faith but you be like "Okay, you say you're drawing strength from your faith but you not actually, or how else can we help this situation?"*

Lastly, participants believe that social workers who incorporate spirituality into their intervention will be able to provide meaningful support, thus, increasing mental health capacity and decreasing stress. As such it is imperative that social workers in healthcare have a knowledge of all religions, as spirituality is often used as a source of strength for individuals, it further provides comfort, consolation and guidance, therefore it can be utilised as a tool for empowerment (Kirst-Ashman, 2013:91). As discussed above, these suggestions by participants would increase the rewards experienced by individuals when receiving social work services and decrease consequences, therefore making engagement in these services more likely, as discussed in the Health Belief model (Carpenter, 2010:4).

3.8. SUMMARY

This chapter has provided a description of the research methods and methodology utilised, as well as the ethical considerations. Furthermore, the research findings were discussed, including

the biographic findings and the thematic analysis of four main themes, as well as their sub-themes. The literature reviewed and the theoretical framework underpinning the study supported some of the findings, however, there were certain areas that findings differed from the literature. The findings from participants indicated that Charismatic Christianity mainly increases positive health-seeking behaviours, but that certain individuals may be deterred from healthcare services due to the belief in divine healing.

The following chapter discusses the key findings, conclusions and recommendations.

CHAPTER FOUR

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

The previous chapter presented an in-depth discussion of the empirical findings from the semi-structured interviews, using a qualitative approach. Chapter four will discuss the extent to which research aim and objectives were met, the limitations of the study, the key findings, conclusions, and recommendations.

4.2. SUMMARY

The aim of this study was:

- To conceptualise and contextualise spiritual factors influencing health-seeking behaviour from a health belief perspective.
- To explore and describe spiritual factors influencing health-seeking behaviour of Charismatic Christians in Johannesburg.
- To make suggestions to improve social work services in healthcare, taking into consideration the factors influencing health-seeking behaviour among Charismatic Christians in Johannesburg.

4.2.1. Aim and objectives

The aim of the study was as follows:

To explore the spiritual factors influencing the health-seeking behaviours of Charismatic Christians in Johannesburg.

The aim was met by the achievement of all the objectives, discussed below.

4.2.1.1. Objective 1:

To conceptualise and contextualise spiritual factors influencing health-seeking behaviour from a health belief perspective.

The objective was achieved through the literature review, which provided information on the spiritual factors that affected health and health-seeking behaviour. The literature review conceptualised and contextualised spiritual factors influencing health-seeking behaviour from a

health belief perspective, by discussing the following in chapter two: Spiritual factors, from both a national and an international context, regarding the broad spiritual factors that influence health-seeking behaviour; Core beliefs of Charismatic Christianity; Health beliefs of Charismatic Christianity; and Health-seeking behaviour of Charismatic Christians. As spirituality influences life decisions, actions, and personality, it was expected that spirituality would be a factor of health-seeking behaviour.

4.2.1.2. Objective 2:

To explore and describe spiritual factors influencing health-seeking behaviour of Charismatic Christians in Johannesburg.

The second objective was achieved through the provision of literature in the literature review which identified several beliefs and behaviours of Charismatic Christians and their effect on health-seeking behaviour as defined in section 2.4. Overview of Charismatic Christianity, 2.4.3. Core beliefs of Charismatic Christianity, 2.4.4. Health beliefs of Charismatic Christianity and 2.4.5. Health-seeking behaviour of Charismatic Christians. However, the literature review provided limited research (national and international), specific to the health-seeking behaviours of Charismatic Christians, especially in terms of physical health, thus indicating the research gap for the underpinned study. However, the objective was further achieved through the key findings of the empirical study in chapter three, which found several core factors that underpinned the health-seeking behaviour of Charismatic Christians. In the key findings of chapter three's empirical study, theme one: factors influencing health-seeking behaviour, sub-theme 2.5. spiritual factors, spirituality was seen as a factor influencing the health-seeking behaviour. As such, the research study was able to conceptualise and contextualise the spiritual factors that influence health-seeking behaviour through literature of previous studies and the key findings.

The key findings in conjunction with the available literature indicated that there were spiritual factors of Charismatic Christians that influenced health-seeking behaviour, in instances of health promotion and instances of non-compliance to healthcare services. As such, the research study was able to explore and describe spiritual factors of Charismatic Christians in Johannesburg that influenced health-seeking behaviour.

4.2.1.3. Objective three

To make suggestions to improve social work services in health care, taking into consideration the factors influencing health-seeking behaviour among Charismatic Christians in Johannesburg.

The third objective was achieved by describing the role of the social worker in current healthcare settings in an in-depth review of current literature, as described in chapter two, namely, the role of the social worker. Furthermore, the objective was achieved through the suggestions provided by participants in the key findings of chapter three's empirical study, theme 4: social work in the healthcare setting, sub-theme 4.2. The potential role of social workers in integrating health and spirituality in healthcare settings, regarding possible actions that social workers can undertake to incorporate the spirituality of Charismatic Christians into healthcare services. With the aim of improving social work services to promote positive health-seeking behaviours. This objective was further achieved in section 4.5.4. Theme four: social work in the healthcare setting, which provided recommendations for future social work services and the role of social workers in integrating spiritual factors with healthcare services. As such suggestions were made to improve social work services, while considering the factors that affect the health-seeking behaviour of Charismatic Christians in Johannesburg.

4.2.2. Research question

The research question for this study is as follows: **What are the spiritual factors influencing health-seeking behaviours of Charismatic Christians in Johannesburg, Gauteng.**

The research question was answered through conducting a qualitative research study which involved interviewing ten Charismatic Christians from a Charismatic Christian church - New Creation Family Church in Johannesburg, Gauteng, who had sought healthcare in the past year. One-to-one semi-structured interviews were utilised to collect the data, which was then analysed. Themes and sub-themes generated during analysis were then discussed in-depth in chapter three. Four themes, as well as their sub-themes emerged in the process of answering the research question.

Table 4.1 below provides an overview of the themes and sub-themes generated to answer the research question.

Table 4.1: Themes and sub-themes

	Themes	Sub-themes
1	Approaches in health-seeking behaviour	1.1. Self-care and non-professional advice 1.2. Lifestyle choices 1.3. Seeking professional healthcare services
2	Factors influencing health-seeking behaviour	2.1. Political influences, structural resources, and modern medicine 2.2. Socio-economic factors 2.3. Family structure and socio-cultural factors 2.4. Interrelationships and Individual factors 2.5. Spiritual factors
3	The value, beliefs, and practices of Charismatic Christianity	3.1. Church practices, biblical and pastoral teachings 3.2. Spiritual grounding, comfort, and guidance 3.3. Miracles and healing vs. medical intervention 3.4. The presence of spiritual attacks and the disregarding of physical and mental illnesses
4	Social work in the healthcare setting	4.1. The lack of interaction with and knowledge regarding social workers in healthcare settings 4.2. The potential role of social workers in integrating health and spirituality in healthcare settings

4.2.3. Challenges and limitations of the study

- A limitation of the study is related to sample size, which was relatively small, due to the use of interpretivism which informed the qualitative approach. Only ten participants were

interviewed for the purposes of this study. This limited the researcher in their ability to make generalisations to the larger population of the New Creation Family Church in Randburg, as well as members of Charismatic Christians in Gauteng. However, generalisations could be made to similar populations to those in the study sample.

- Due to the fact that the data obtained was qualitative in nature, it is important to remember that qualitative data is subjective in nature. As such, the researcher used certain constructs of trustworthiness to ensure that the study remained trustworthy and non-biased.
- Furthermore, participants provided subjective accounts which may have contained personal bias. As subject matter shared could have been sensitive for the participants, participants were informed that they would be given a pseudonym to protect their identity, in the hope that participants would feel more comfortable sharing trustworthy, sensitive information.
- Generalisations were further impeded due to the qualitative nature of the study, using a non-representative sample of Charismatic Christians from New Creation Family Church, Randburg. As such, the sample did not represent the broader Gauteng, nor South African context of Charismatic Christians. Firstly, volunteer sampling was used to recruit the participants through an announcement of the research on the church WhatsApp groups. Then those who contacted the researcher using the contact details provided in the announcement, were informed of the study. If interested, purposive sampling was used to select those who met the selection criteria and they were then sent a letter of informed consent via email and once returned an interview was arranged. This further created a non-representative sample as some individuals from the population were excluded by the criteria.
- There may have been issues inherent to the semi-structured interview. This is due to the fact that when participants were asked the same question, it was apparent that they understood it in different contexts, thus providing various answers that were not intended from the question. To counter this, the researcher would probe and repeat the question in a different manner in order to achieve the same understanding between all participants. This may have been a result of English not being the first language of all participants, as such, creating a language barrier for those of other home-languages.
- The study was a time-consuming process, as large amounts of data were collected, which needed to be analysed with the creation of themes and sub-themes. To ensure that the large amount of data was recorded accurately, interviews were recorded and then transcribed verbatim. Although this was a time-consuming process, it ensured that the researcher became familiar with the data and gave accurate depictions of participants' viewpoints. Furthermore,

codes were limited to only those directly related to the research question to ensure using the accurate viewpoints of participants while saving time in the data analysis process.

4.3. KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.3.1 Key findings and conclusions from the literature review

The theoretical framework chosen for this study was discussed in chapter one. The social learning theory and the health belief model were selected for this study because they provided insight into how individuals observe, learn and internalise new behaviours. As such, both theories provided a theoretical framework to explain the health-seeking behaviours of Charismatic Christians, as well, as provided theory as to why certain health behaviours would be internalised and repeated, while others would be discarded. As such, the theoretical framework guided the research study as well as the literature review.

The literature review provided an overview of health in the South African context. Including the health trends, health services available and the interrelationship between mental and physical health. This was necessary in understanding why South Africans seek healthcare and in what manner they would achieve this. Furthermore, the literature review indicated spiritual factors as contributing towards health-seeking behaviour and more specifically, provided the core beliefs and known health beliefs of Charismatic Christians, thus contributing to meeting the above objectives.

It can be seen that South Africans have various methods to seek healthcare services which are specifically targeted at the prevention and treatment of the communicable and non-communicable diseases within the South African context. Due to the profile of health trends in South Africa, the literature recommends that South Africans should be seeking formal healthcare services from a primary level of healthcare to minimise the burden on the healthcare system in the secondary and tertiary levels and to prevent the development of chronic or life-threating illnesses.

The literature review indicated that there are two approaches to health-seeking behaviour, namely, seeking and receiving help at the onset of illnesses; and a process defined by a psychological perspective that both encourages and inhibits certain health-seeking behaviours. For the purpose of this study, the second approach informed the research study as it incorporated the factors that affect health-seeking behaviour prior to, during and after the onset of illness. The literature review provided both national and international studies that discussed the various factors influencing health-seeking behaviours. These factors were categorised as individual,

spiritual, socio-economic, socio-cultural, and political/structural. It was important to note that factors were therefore not only individual in nature but also influenced by culture, spirituality, and societal factors at large. As such it is recommended that educational efforts that are culturally and spiritually sensitive are utilised to promote positive health-seeking behaviours.

The literature review further provided an in-depth analysis into Charismatic Christianity, by defining the core beliefs of Charismatic Christians and how this affects their behaviour. More specifically, the health beliefs of Charismatic Christians were identified and research provided that these beliefs did impact the health-seeking behaviour of Charismatic Christians. This was supported by the theoretical framework's social learning theory that indicated that individuals within religious groups would be socialised and imitate the behaviours of those within their spiritual groups. As such, it was expected that Charismatic Christians would have similar health-seeking behaviours.

During the literature review the gap for the research study was identified as relatively few research studies provided information detailing the health-seeking behaviours of Charismatic Christians, especially in terms of physical health. Despite this, the limited research available did indicate the belief of Charismatic Christians in divine healing and deliverance which both played a role in hindering and encouraging health-seeking behaviour. As such, it was recommended that further research be done into the specific factors of spirituality that affect health-seeking behaviour of Charismatic Christians, to provide a more detailed description of the health behaviours of Charismatic Christians.

Lastly, the literature review provided a discussion of the role of social workers in healthcare systems. It was discussed that as part of the multi-disciplinary team, social workers would work as part of the team to provide holistic care for patients. The literature identified that social workers would work with patients and their families during psycho-social assessments, counselling, educational training and during the discharge and rehabilitation phase. As such, social workers would need to understand patients in their entirety, including their spirituality, to provide non-judgmental, sensitive, and empowering services. As such, it is recommended that social workers gain knowledge and understanding into the factors that affect health-seeking behaviour in different religious affiliations, in order to provide holistic care.

4.3.2 Key findings, conclusions and recommendations from the empirical study

This section provides the key findings and conclusions of each of the four themes and their sub-themes. Lastly, recommendations will be provided for each theme, specifically related to social work practice, future research, healthcare fields and education.

4.3.2.1 Theme one: Approaches in health-seeking behaviour

The first theme focussed on the approaches to health-seeking behaviour that participants engaged in and was divided into the following sub-themes: self-care and non-professional advice; lifestyle choices; and seeking professional healthcare services.

Key findings

The participants indicated that seeking professional healthcare was not usually their first step in the health-seeking process. Participants generally rather sought advice from non-professional persons and engaged in various forms of self-care. They would generally, initially use their own intuition about how to treat the current illness. If they were unsure of what their illness was or whether they needed professional care, they would often consult their friends, family or the internet for advice, prior to seeking professional healthcare. At the onset of illness participants would frequently engage in the process of self-medicating with non-prescription medication, but if symptoms progressed participants would generally seek professional healthcare services. The theoretical framework supports these findings as the health belief model indicates that in order for a person to choose a specific health behaviour, they would need to experience a health concern and would need to accept that seeking healthcare would be successful in eliminating the threat. As such, if the individual believes that self-medication will be successful in eliminating illness, they will engage in this behaviour, especially if the consequences of self-medication are less than those of seeking formal healthcare.

Participants indicated that they chose life-style choices that promoted health. The main referenced lifestyle changes were exercise and diet. However, despite acknowledging the need for these behaviours, several participants noted that they either do not participate in these behaviours or that they do not participate to the extent that they should, to ensure health. Furthermore, participants failed to mention engaging in prevention methods related to the formal healthcare system such as, vaccinations and screening tests. In conjunction with this, participants also mentioned abstaining from certain risky behaviours that affect health negatively, specifically alcohol and drugs. Lastly, pertaining to mental health, participants noted that they engage in certain behaviours to limit stress and find social support systems. This can be linked to the

theoretical framework's social learning theory, whereby it is theorised that through the process of socialisation, individuals imitate and observe the behaviours of those around them. As such, differential association within the Charismatic Christian community would lead to a process of individuals observing abstinence from risky behaviours, due to spiritual beliefs, this would in turn lead to imitation of this behaviour, thus individuals would be less likely to partake in risky behaviours.

Several participants noted that their mental health was more important to them than their physical health, as such, they placed more effort in ensuring that they maintain mental health and less on physical health. As such, not only did participants engage in preventative measures such as, engaging in supportive relationships and increasing coping mechanisms, but participants were also willing to seek professional mental healthcare to maintain good mental health.

Participants indicated that they were willing to seek professional healthcare services if they experienced severe symptoms, especially pain, or if symptoms had not decreased over a period of two to seven days. Professional healthcare was seen as a last resort and would only be done in the event that other methods had not been successful. In the case of severe symptoms, participants were more likely to seek healthcare immediately, in case of physical health general practitioners were consulted most frequently, where in mental health counsellors and psychologists were consulted. In both instances, participants were willing to be referred to other professionals if necessary. The theoretical framework, social learning theory supported this finding as it theorises that individuals are expected to make decisions when confronted by various situations, thus learning that certain responses result in favourable outcomes, while other responses may lead to less favourable or undesired outcomes. As such, if individuals experience severe symptoms, thus leading to unfavourable consequences they would learn through direct experience to engage in health-seeking behaviours more quickly, when experiencing similar symptoms in the future through the process of reinforcement.

Lastly participants provided mixed accounts of compliance. Some indicated that after receiving professional healthcare they are likely to follow treatment advice until they have restored their health. However, other participants indicated that even after receiving professional healthcare services, they were likely to become non-compliant with treatment plans or chose to discontinue treatment.

Conclusions

Participants are not averse to seeking professional healthcare services, however, unless the symptoms are severe, participants will engage in other methods of self-care prior to seeking healthcare services. As participants see an increased value in mental health, they are more willing to seek professional healthcare prior to the onset of severe symptoms. Furthermore, it is evident that despite participants being willing to seek professional healthcare, if deemed necessary, there are mixed findings as to whether they would remain compliant with treatment plans.

Participants engage in lifestyle choices that promote certain behaviours, discouraging others to promote health. It must be noted that specified methods are not directly linked to formal healthcare systems and as such, it can be assumed that participants are receiving healthcare at the onset of symptoms. Thus, receiving secondary and tertiary levels of healthcare, they are not entering the system at the primary level as encouraged by government.

Recommendations

- There is a need for healthcare systems to promote formal primary care, through screening and vaccinations. As such there is a need for programme development which will encourage these initiatives.
- As individuals' main preventative measures include healthy eating and exercise, individuals should be assisted in this process, primarily through encouraging the use of public spaces, such as parks, that are free of charge and allow for physical activity. Also, by providing nutritional information on all store-bought foods.
- As the internet is used as a source of medical information, healthcare systems should ensure that professional medical websites can be accessed, that contain information about which symptoms need immediate intervention. In the future this can also be translated to an app for smartphones which can be more easily accessed.
- Social workers should work as part of the multi-disciplinary team and have education-based community programmes that encourage primary and preventative care, as well as education regarding which symptoms should be classified as severe. This will be especially beneficial for rural communities that do not have access to the internet or smartphones for professional healthcare information.

4.3.2.2 Theme two: Factors influencing health-seeking behaviour

Theme two recorded all the factors identified by participants as affecting their health-seeking behaviour, in both promotive and inhibitive ways. Factors were divided into five sub-themes: political influences, structural resources and modern medicine; socio-economic factors; family structure and socio-cultural factors; interrelationships and individual factors; and spiritual factors.

Key findings

It was noted by participants that similar factors that influenced individuals in the literature review, influenced the participants in research study. As such the key findings were as follows:

Participants were more likely to access healthcare services if they were easily accessible with limited challenges, due to the demographic profile of participants they noted that healthcare services were accessible due to access to private healthcare and relatively little interaction with government healthcare, which they noted had more challenges such as over-crowding and lack of resources and xenophobic tendencies. As such, participants noted that individuals who needed to access government services, may be less inclined to do so, due to the challenges experienced. Participants reported that they accessed services of various medical professionals including, general practitioners, dieticians, physiotherapists, pharmacists, clinics and private or public hospitals. Furthermore, participants appeared to be more likely to access resources if they were easily available to them and required relatively low effort from participants. Therefore, participants were more likely to access resources if they were made available at their place of work or if they did not need to travel to receive services. These results were supported by the theoretical framework's health belief model, which states that perceived barriers, including any negative consequences that health-seeking behaviour may incur, including expenses, effectiveness, and level of danger. As such, if individuals are dissatisfied with health services or if they find accessing healthcare services to have more challenges than benefits, they would be less likely to engage in these services.

Participants noted that they trusted modern medicine and that they were more likely to access this type of medicine, as it is rooted in science and has been thoroughly researched. Thus they did not negate receiving formal healthcare services with allopathic medicine, when deemed necessary for their health.

Medical aid was a large factor in participants receiving formal healthcare, due to the fact that they had access to private healthcare services with relative ease. As most participants described

themselves as middle-class and well educated, they indicated that they had medical aid. Despite this, medical aid was restrictive in terms of choice and funds available, in these instances, participants were found to be less likely to access professional healthcare services, unless symptoms were severe, or if participants noted the treatment value, in an effort to avoid depleting medical aid funds or needing to make co-payments that they were more able to use these funds when there were emergencies.

Gender did not appear to influence health-seeking behaviours, as both male and female participants indicated that they would seek healthcare services if they deemed these services necessary due to severity of symptoms. Furthermore, there appeared to be no clear gender roles or norms in participants families that made healthcare decisions. It appeared that each family had their own dynamic and certain persons were given this role. As such, health-seeking behaviours were not influenced by gender within the family system. These persons would make decisions, based on severity of symptoms and whether they deemed healthcare necessary.

It was noted that societal expectations further impacted health-seeking behaviours. This included included their personal beliefs and upbringing, which was influenced by family, friends, and society at large. It was noted that expectations from society encouraged certain behaviours, while others are discouraged. Depending on the society, this influence can either positively affect your health-seeking behaviour, for example exercising and healthy eating; or the influence can be negative, such as the overuse of or indulgence in alcohol and recreational drug consumption. This is supported by social learning theory in the theoretical framework which indicates that learning, which indicates that personality or social behaviour is enforced through either a perceived reward to encourage the behaviour; or a punishment to deter the behaviour. As such individuals are likely to engage in imitated health-seeking behaviours from observations which were reinforced through rewards than in behaviour that led to unpleasant or wanted consequences.

Symptom severity appeared to influence health-seeking behaviour. This was usually linked to what participants described as knowing oneself. If participants felt that symptoms were abnormal to their normal symptoms which indicated mild illness, they would be more likely to seek healthcare. Furthermore, participants who had a history of health problems, were more likely to seek healthcare quickly, as they did not want severe symptoms to develop. Linked to this was the level of trust that participants had with healthcare practitioners. They were more likely to seek and adhere to treatment if they trusted the healthcare professional. This is further explained by

reinforcement in the theoretical framework's health belief model, as individuals who have experienced severe symptoms are encouraged to engage in behaviour that will reduce symptom severity.

Participants revealed mixed responses regarding whether their spirituality influenced their health-seeking behaviour. However, three main pathways of this influence were discussed. Firstly, **spirituality did not directly influence health-seeking behaviour**, but it provided a form of support, comfort and a source of strength when faced with illness, however this did not mean that they disputed the occurrence of miracles. Secondly, **spirituality provided participants with certain values and teachings that encouraged them to live healthier lifestyles**, as such, this was seen as encouraging positive health-seeking behaviours. Lastly, **some teachings provided participants with the belief that God would provide healing**, as such professional healthcare services were not necessarily needed. As a result of these aforementioned pathways, individuals experienced negative effects regarding their health-seeking behaviour, as they would prolong illnesses by delaying seeking professional healthcare, and in some instances, would discontinue or not adhere to treatment methods provided by healthcare professionals.

Conclusions

The more accessible healthcare services are, and the less individual effort is required, the more likely they will be accessed. Thus, as it currently stands, participants indicate that they would rather access private healthcare than public healthcare. Furthermore, if individuals trust allopathic medicine and their healthcare providers, they are more likely to access these services.

Medical aid can both increase and decrease health-seeking behaviour, as those with medical aid have access to private healthcare services, thus they are more likely to use them. However, due to fund limitations, some participants are less likely to access healthcare services, unless having severe symptoms to avoid co-payments and fund depletion. Linked to this was symptom severity, participants were more likely to engage in formal healthcare services if they saw symptoms as severe, abnormal, or life-threatening, than they were if they viewed symptoms as mild - moderate.

Expectations from personal beliefs, family, friends, and society, influenced health-seeking behaviour, as some behaviours are encouraged while, others are discouraged. Gender did not appear to influence the likelihood of accessing healthcare services.

Lastly, spirituality influences health-seeking behaviour in differing ways. Health-seeking behaviour is encouraged when spirituality is viewed as a source of strength, or through the

promotion of healthy behaviours through various teachings. However, it can decrease health-seeking behaviour when individuals are waiting for instances of divine healing, thus they prolong seeking healthcare services.

Recommendations

- Individuals should have access to formal platforms that help indicate whether symptoms deem medical attention. This could be through smart phone apps, medical websites or call centers with trained personnel.
- Companies should be encouraged to incorporate preventative measures as part of their benefits. For instance, have screening days or vaccination days. This would be beneficial, as individuals would be more likely to access these services when they are convenient.
- As is done with some medical aid schemes, medical aids should offer incentives for individuals to partake in preventative measures. Such as a point system that offers different rewards for partaking in healthy measures.
- Lastly, social workers should offer services to companies to provide individual and group counselling or workshops to educate, promote coping, resilience, and healthy living, thus impacting health positively. Social workers could then also refer individuals to healthcare services in the presence of risk factors, such as referral to psychologists for severe emotional distress, or specialists in healthcare such as medical specialists or other professionals such as dieticians and bio-kineticists.

4.3.2.3 Theme three: The value, beliefs, and practices of Charismatic Christianity

Theme three relates to the values, beliefs and practices of Charismatic Christians and the effect of this on health-seeking behaviour. As such the spiritual influence on health-seeking behaviour was seen in four sub-themes. These included, church practices, biblical and pastoral teachings; spiritual grounding, comfort, and guidance; miracles and healing vs. medical intervention; and the presence of spiritual attacks and the disregard of physical and mental illnesses.

Key findings

Participants defined Charismatic Christianity similarly to the literature, with the most important aspect being the daily dedication of their life to the Father, the Son, and the Holy Spirit, through a conscious effort to develop a relationship with God. Typical practices included attending church, devotions, prayer, worship and fasting. However, participants indicated that they had begun to challenge aspects of Charismatic Christianity and perform their own research, namely that they no longer just believe what they have been told, thus influencing a shift in traditional beliefs.

Charismatic Christianity encourages health-seeking behaviour in several instances. Firstly, through teachings that encourage living in margin, thus teaching control which effectively benefits mental health. Furthermore, that the body is a temple of God, as such it should be treated with respect, as such harmful behaviours are discouraged, while health promotion behaviours are encouraged. Lastly, teachings of the Bible show Jesus using rudimentary medicine for healing and parables that encourage helping others heal, thus healthcare practices can be seen as biblical in nature and are thus encouraged. Secondly, Charismatic Christianity provides spiritual grounding that in turn helps them make good decisions, thus, limiting risky behaviours and leading to more healthy lifestyles. Lastly, participants indicated that prayer was a form of guidance regarding what actions they should take regarding their healthcare, thus being accepting and comfortable with utilising formal healthcare services. As previously stated, the theoretical framework's social learning theory, theorises that through the process of socialisation, individuals will observe and imitate the behaviours around them. As such, individuals in the Charismatic Christian community are likely to observe and imitate the behaviour of other Charismatic Christians, which was influenced by Charismatic Christian teachings.

Furthermore, participants indicated that their religion did not prohibit them from seeking-healthcare. They indicated that they would seek healthcare and that their spirituality served more as a source of comfort and support provided through both God and the community. This was through scripture and prayer, which participants found to be a source of encouragement, guidance, and healing of emotional pain, thus increasing their coping capacity and decreasing their feeling of stress. Furthermore, through providing a support structure in terms of the church community, participants were further able to describe feelings of support and comfort. As participants are feeling support and comfort, they are securing friendships and a community which contribute towards increased mental health capacity.

Participants indicated a belief in divine healing through miracles, which was sought through the process of prayer. However, this belief in miracles, at times, resulted in individuals refusing healthcare or not adhering to treatment plans, therefore, negatively affecting health-seeking behaviour. This was especially true if their belief in God's healing powers was greater than their belief in healthcare services. It is important to note that if a miracle were not fulfilled, disappointment and loss in faith could occur, which if not addressed, caused emotional distress for individuals, thus having a negative impact on their mental health. This could be further explained by the health belief model in the theoretical framework which stated that in order for a person to choose a specific health behaviour, they would need to experience a health concern

and they would need to accept that seeking healthcare would be successful in eliminating the threat, with relatively few consequences. However, in the case of Charismatic Christians, if they perceive God as a being that will eliminate health threats with few consequences, they are likely to rely on God for healing rather than seeking professional healthcare services.

Lastly, if participants or their community, viewed spiritual attacks as causing an illness and not biological factors, they would be more likely to rely on spiritual healing and less likely to seek professional healthcare services, which was especially in the case of mental health. As such, participants indicated that mental illnesses were often attributed to a spiritual attack, thus professional healthcare services were not seen, as necessary.

Conclusions

The belief in having a relationship with God through prayer and spiritual beliefs, both increased and decreased health-seeking behaviour of participants.

Charismatic Christianity was found to encourage health-seeking behaviour through teachings of self-control, self-respect, and healing through medicine. Furthermore, spiritual grounding encouraged healthy behaviours while discouraging risky behaviours. Lastly, a belief in guidance from God and his hand in healthcare services, encouraged participants to utilise formal healthcare services.

Religion did not prohibit participants from seeking-healthcare, but instead encouraged care, both self-care and formal healthcare, however, spirituality served as a source of comfort and support provided through both God and community. Thus having positive impacts on both mental and physical health.

Lastly, Charismatic Christianity can deter individuals from health-seeking behaviour as they have a belief in divine healing from God, thus it is not necessary for them to seek formal healthcare services. This deterrence was further likely if individuals believed that spiritual attacks resulted in an illness and not biological factors. Thus, they would be more likely to rely on spiritual healing and less likely to seek professional healthcare services. This was especially the case with regards to mental health.

Recommendations

- Leaders within the Charismatic Christian Church receive training on how to incorporate healthcare principles into sermons and teachings. It does not appear that leaders are against

healthcare, thus the healthcare sector could utilise these leaders to encourage health-seeking behaviour and the use of formal healthcare resources.

- As church leaders provide spiritual guidance and in some cases forms of counselling, it is recommended that they are trained about when it is necessary to refer individuals to the formal healthcare sector to improve both mental and physical health. As such, these leaders should be provided with resource lists, to enhance this process.
- Patients should receive holistic treatment, as such, their spiritual needs should be met. It is therefore necessary to identify the religion of patients and whether they would want these spiritual needs met. This could be addressed in the intake phase of patients, where they can choose to identify themselves as a certain religion and indicate what religious practices, they would want included or excluded in their treatment plan, for example. access to a bible or prayer.
- Lastly, Charismatic Christian leader should be incorporated into the multi-disciplinary team to provide for the spiritual needs of patients and their families of this denomination. Especially in the cases of long-term, life-threating illnesses or end-of-life care.

4.3.2.4 Theme four: Social work in the healthcare setting

The final theme related to the role of social work and social workers in the healthcare setting. Two sub-themes were generated, namely, the lack of interaction with and knowledge regarding social workers in healthcare settings; and the potential role of social workers in integrating health and spirituality in healthcare settings.

Key findings

It was found that none of the participants had any contact with a social worker in the healthcare setting. This lack of contact with social workers also indicated that participants had little knowledge of the role or purpose of a social worker in the multi-disciplinary team. However, they reported that they could see the value of having a social worker as part of the multi-disciplinary team, especially with regards to integrating spirituality with healthcare services, and would want this service provided to them. They believed that social workers who incorporate spirituality into their intervention will be able to provide meaningful support, thus, increasing mental health capacity and decreasing stress. However, some participants indicated that they did not see the need for integrating spirituality and healthcare services, but these participants were in the minority.

Participants indicated certain values that social workers would need to achieve this role of integration. Firstly, social workers would need to have knowledge of Charismatic Christians and their beliefs and realise that this is a broad spectrum, meaning that not all can be treated alike and should be attended to on a case-by-case basis. Secondly, due to the beliefs of Charismatic Christians, social workers may need to engage in religious practices, especially prayer, as some individuals may find this as a necessary component in the treatment plan. Thirdly, social workers would need to have a non-judgemental and accepting attitude to create rapport, trust, and support to avoid causing offence or withdrawal. Lastly, it is important for social workers to remember that all individuals have autonomy, and their choices should be respected. Therefore, social workers should work with the patient and the multi-disciplinary team to find treatment methods that patients are comfortable with, relating to their religious values.

Conclusions

Participants have had limited contact with social workers in the healthcare setting, thus limiting their knowledge regarding the role of social work. It was further concluded that the majority of participants saw the value of receiving social work services, especially with regards to integrating spirituality and healthcare.

Lastly, participants who want to receive social work services, request social workers who are knowledgeable about Charismatic Christianity, who are willing to incorporate religious practices into their treatment plan. They should remain sensitive to their religious beliefs, and be empathic and non-judgemental to patients, allowing them to exercise their right to autonomy. As such, it can be concluded that participants are willing to engage with social workers in the healthcare setting if the above values are achieved.

Recommendations

- Registered social workers in healthcare settings receive sensitivity training to increase their knowledge base regarding the spiritual factors that influence health-seeking behaviours of Charismatic Christians, as well as that of other religions. This will help ensure non-judgmental, well-informed, and sensitive attitudes when providing services.
- The curriculum of undergraduate and postgraduate degrees in the social work field should be modified to include training regarding integrating a sensitivity and knowledge of the diverse religious perspectives into social work services.
- Upon hospital admission, especially in the case of chronic, severe, or end-of-life cases, referrals should be made to social workers, to perform an initial assessment with patients and

their families. These assessments are often already done but can be improved to include an assessment of patients' religion practiced and important needs in terms of their spiritual practices, to achieve holistic care.

- During the therapeutic phase of social work intervention, social workers work with the patient's spirituality, to provide a further source of comfort, strength, and guidance, thus increasing coping capacity. This can be done through several activities such as providing relevant scripture, praying with the patient or liaising with church leaders or to perform such religious practices to meet the needs of the patient.
- Patients should have the opportunity and platform to report misconduct in the multi-disciplinary team, in terms of the neglect or disrespect for their spirituality. This is necessary to firstly, govern the behaviour and actions of the multi-disciplinary team and secondly, to allow these persons an opportunity to receive non-judgmental care to minimise the chance that they would avoid seeking healthcare due to fear of judgement or non-acceptance.

4.4. RECOMMENDATIONS FOR FUTURE RESEARCH

As there is a limitation of the study, this study was only conducted with participants from one Charismatic Christian church in Randburg. As such the results cannot be generalised. It is therefore recommended that a quantitative study be designed that can be administered in all parts of South Africa on a larger scale, to gather data that can be generalised in the Charismatic Christian South African context, with the goal of improving service delivery in healthcare sectors.

It is further recommended that research be conducted into programme development, that can increase the health and health-seeking behaviours of Charismatic Christians in the primary, secondary, and tertiary levels of healthcare. These can be ministered by social workers in individual, group and community levels.

4.5. FINAL CONCLUDING REMARKS

From this study it can be seen that the health-seeking behaviour of Charismatic Christians is influenced by similar factors to other groups of people. However, it is evident that there are certain factors directly linked to Charismatic Christianity, which does influence health-seeking behaviour. As such it can be said that within this research study, Charismatic Christians are encouraged to engage in health promotion behaviours. They further find comfort within their religion, thus increasing their coping capacity and strengthening their mental health. However, for certain Charismatic Christians, health-seeking behaviour can be influenced negatively, as the belief in Divine healing, discourages seeking healthcare. Despite the findings of this research, it is

necessary to either replicate this study in other parts of South Africa or to design a large-scale study, where the findings can be generalised, and services can be improved to encourage improved health and health-seeking behaviour amongst Charismatic Christians.

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APPENDICES

Appendix 1: Ethical approval

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Humanities 100
Since 1919

31 July 2020

Dear Ms SA Beukes

Project Title:	The spiritual factors influencing the health-seeking behaviour amongst the Charismatic Christians in Johannesburg.
Researcher:	Ms SA Beukes
Supervisor(s):	Dr CL Carbonatto
Department:	Social Work and Criminology
Reference number:	14205018 (HUM001/0420)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 31 July 2020. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

Sincerely,

Prof Innocent Pikirayi
Deputy Dean: Postgraduate Studies and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof I Pikirayi (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr A-M de Beer; Dr A dos Santos; Ms KT Govinder Andrew; Dr P Gutura; Dr E Johnson; Prof D Maree; Mr A Mohamed; Dr I Noomè; Dr C Puttergill; Prof D Reyburn; Prof M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

Appendix 2: New Creation Family Church letter of approval

NEW CREATION FAMILY CHURCH

9th June 2020

To whom it may concern

This letter serves to confirm that New Creation Family Church is aware of the research project that has been undertaken by Simone Beukes, as a Master's student from the University of Pretoria. This letter confirms that New Creation Family Church is willing to partake in the study, provided that all ethical guidelines are adhered to. Furthermore, the church agrees to participate but acknowledges the individual rights of church members and supports their rights to voluntary participation and informed consent.

Yours faithfully

PAUL DENNISON
SENIOR PASTOR

IN FELLOWSHIP WITH CHURCH OF THE NATIONS SOUTHERN AFRICA & INTERNATIONAL

Cnr Winston Ave & Gemsbok Road, Robinhills, Randburg ◆ PO Box 1638 Cresta 2118 South Africa
Tel: +27 11 792 1151 ◆ e-mail: admin@newcreation.co.za ◆ website: www.newcreation.co.za

Appendix 3: Informed consent letter

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Humanities 100.
1919 - 2019
Department of Social Work & Criminology

Date:

Name: Simone Beukes
Email: u14205018@tuks.co.za
Cellphone No: 082 209 7798

LETTER OF INFORMED CONSENT

SECTION A: RESEARCH INFORMATION

Research Information

This letter serves to invite you to participate in a study of the spiritual factors influencing health-seeking behaviour amongst Charismatic Christians in Johannesburg. The informed consent gives a brief explanation of the purpose and procedure of the research and the rights of participation. Please go through the form before you make an informed decision regarding your participation.

Title of the study

Spiritual factors influencing the health-seeking behaviour amongst Charismatic Christians in Johannesburg.

Purpose of the study

The purpose of the study is to explore and understand the spiritual factors that influence the health seeking behaviours amongst Charismatic Christians in Johannesburg.

Room 10-5 HSB Building
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Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Procedures

You have been informed of the study and provided your contact details for the researcher to contact you to partake in the study. The researcher will conduct a face- to-face interview with you in order to collect data on Charismatic Christians. Once you sign this letter, you will agree to partake in the study. The researcher will arrange to conduct an individual interview with you when it suits you best. The interview will be recorded, with your permission, to ensure that all the information you are sharing is captured for research purposes. Please note that the recording will only be used for the purpose of data analysis of the research and will be kept confidential. A semi-structured interview schedule will be used to guide the interview process. Interviews will be for the duration of one hour and will be conducted at Oasis Haven, 54 Winston Avenue, Robin Hills.

Risks and discomforts

Please note that the researcher does not intend to put you under any risk or discomfort with the information you will share. There is a possibility of emotional harm related to the sharing and exploration of your religion. The researcher will debrief you after the interview is concluded and should you experience a need for counselling, you will be referred to Beverley Beukes, a professional counsellor for intervention, which will be provided free of charge. You are free not to answer any question that will make you feel uncomfortable during the interview.

Benefits

You will not receive any form of remuneration/ compensation/ incentives for participating in the study. This study aims to improve the understanding of the spiritual factors that influence the health-seeking behaviour of Charismatic Christians. Thus enabling professionals to render appropriate services.

Participants' rights

Your participation in the study is entirely voluntary and you may withdraw from participation at any time and without negative consequences to you or your family members. Should you wish to withdraw from the study, all data gathered in respect of your interview will be destroyed.

Confidentiality

The information shared during the interview will be kept confidential and will be used for research purposes only. The researcher will protect your identity by using a pseudonym throughout the research process. The only people who will have access to the data, will be the researcher and the supervisor.

Data usage and storage

Please note that the data collected might be used in the future for further research purposes, a journal publication or conference paper. The data collected will be stored in the Department of Social Work and Criminology, University of Pretoria for the period of 15 years as required.

Access to the researcher

You may contact the researcher using the contact details provided above for the duration of the study, should there be any questions or uncertainties regarding the study and your participation. It must be clearly stated, that the role of the researcher is to do research and not to provide counseling or therapeutic services.

Please sign Section B on the next page if you agree to participate voluntarily in the study.

Yours sincerely,

Simone Beukes
Researcher

SECTION B: INFORMED CONSENT OF PARTICIPANT

I ……..., (*Full Name of participant*) hereby declare that I have read and understood the above information. I was given adequate time to consider my participation in the study. I was also given the opportunity to ask questions and all of them were answered to my satisfaction. I hereby give consent to participate voluntarily in this study.

Participant: ----------
Date: ----------
Signature: ----------

I……(*Full Name of researcher*) hereby declare that I have explained the information in Section A: Research Information to the participant and he/she indicated understanding the contents and was satisfied with the answers to the questions asked.

Researcher: ----------
Date: ----------
Signature: ----------

Appendix 4: Data collection tool- interview schedule

Interview schedule

1. **Biographic information**

   1.1 Biographic information

   Age :
   Gender :
   Marital status :
   Number of children :
   Religion :
   Home language :
   Highest qualification:

2. **Knowledge of health care seeking behavior**
   - What does the word health-seeking behavior mean to you?
   - What actions do you take to maintain a good health?
   - How long do you take before consulting a health care provider?
   - Who would you consult first?
   - How does Charismatic Christianity influence your decision to seek / receive medical help when needed?

3. **Understanding spiritual practices within Charismatic Christianity**
   - What does spirituality means to you?
   - What are the spiritual practices you are familiar with in your spiritual group?
   - What is the value of spirituality in your personal life
   - What is the value of spirituality in your community?
   - What are your initial steps you take when you seek help regarding your health?
   - Were you or a family member ever faced with an illness and needed to seek medical intervention which you could not allow due to your spiritual beliefs. Please elaborate?

4. **Spiritual and cultural factors**
   - What spiritual factors contribute to your health-seeking behavior
   - What other factors do you think contribute to your health-seeking behavior
   - What is the influence of spiritual factors on your health-seeking behavior?
   - How did this affect you and your family?

- What would be the consequences for family members?
- Who guides you regarding spiritual health care related issues?

5. **Health-seeking behavior and the family**
    - Can you tell me about your experiences within the family home, being influenced spiritually in seeking health care?
    - Who determines when to go for consultations when a family member is sick?
    - Do you depend on spiritual guidance when you/family members are sick?
6. **Services**
    - What resources are there in your community for health care?
    - What challenges regarding healthcare resources are there in your community?
    - Are these services accessible? Please explain how you have to access these services?
    - Who guides you regarding health care related issues?
7. **Social work intervention**
    - Have you had any interaction with/referral to a social worker regarding health care issues?
    - Is there anything you think a social worker should know about your religion that would help them to understand you better and do their job more effectively?
    - Do you think asking about patients' religions can help health practitioners devise treatment plans that are consistent with their patients' values?
8. **Recommendations**
    - Do you have any recommendations for religious groups in your community that disregard accessing medical health services as a result of their beliefs? Please motivate
    - Do you have any recommendations about integrating spiritual practices into medical health streams? Please motivate

Appendix 5: Oasis Haven venue approval letter

OASIS HAVEN
PO Box 2552, Cresta. 2118.
info@oasishaven.co.za
www.oasishaven.org
Tel +2711 678 8057

To Whom It May Concern

I hereby confirm that Simone Beukes has been given permission to use the office facilities at Oasis Haven (54 Winston Ave, Robinhills) in order to conduct her research interviews for her Master's Degree.

Should you require any further information please do not hesitate to contact me on 082 870 9305.

Regards

Appendix 6: Beverley Beukes confirmation of service letter

OASIS HAVEN
PO Box 2552, Cresta. 2118.
info@oasishaven.co.za
www.oasishaven.org
Tel +2711 678 8057

To whom it may concern,

I Beverley Ann Beukes, agree to provide the necessary therapeutic services within my capacity as a registered social worker (SACSSP Registration Number: 10-48388). These services will be provided in the instance of referral from the researcher, where further therapeutic intervention is necessary.

The services will be provided at the Oasis Haven offices, 54 Winston Avenue Robin Hills, with no cost to the referred client. Contact details are as follows:

Cellphone: 082 870 9305

Work number: 011 678 8057

Email Address: bev@oasishaven.org

Beverley Ann Beukes

Social Worker

10-48388

8/4/2020

Date

OASIS HAVEN
PO Box 2552. Cresta 2118
Tel 011 678 8057
www.oasishaven.org
021-289-NPO
Section 18: 18/11/13/4329
Co Reg: 2001/022477/08

Appendix 7: Confirmation of editing

DECLARATION BY THE EDITOR

The editing done was limited to language completeness and consistency and grammar. Material for editing was received in an electronic format and the mark-up was done using track changes.

Candidate name: Simone Ashley Beukes

Title of mini dissertation: Spiritual factors influencing the health-seeking behaviour amongst the Charismatic Christians in Johannesburg

I declare that I have proofread this mini dissertation in compliance with the above conditions as instructed when engaged by the candidate.

Beverley Ann Beukes

25 April 2021