

Church leaders' experience of supporting congregants with  
mental health difficulties

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the degree of Doctor of Clinical Psychology at the University of  
Wales, Cardiff and South Wales Doctoral Course in Clinical  
Psychology

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## ABSTRACT

Research has suggested that religious beliefs can be important in the recovery from mental health difficulties. In addition, many individuals find it helpful to seek support from church leaders and congregations. However, few studies in the United Kingdom have explored how and why church leaders provide this support.

The study involved interviewing ten church leaders in south Wales regarding their experience of supporting congregants with mental health difficulties. Their accounts were analysed using a grounded theory approach. The results suggested that the leader's concept of mental health difficulties was a major influence in the way in which support was provided. All the church leaders believed that mental health difficulties had a spiritual aetiology, but differed according to whether this was the main cause, or one of many.

Leaders describe providing practical, spiritual, long-term and crisis support to individuals. Spiritual support was prominent and included counselling, bible teaching and prayer. The type of support available was influenced by the values the leaders held and the members of their congregation.

Church leaders varied regarding how much they perceived a need to access mental health services for congregants. The leader's perception of their competency to support the individual and whether they had positive prior experience of mental health services influenced this. The majority of leaders felt under-trained to support people with mental health difficulties and unsure what the mental health services could provide.

A number of barriers may prevent church leaders from accessing services such as feeling mutual suspicion between mental health professionals and the church. Consequently, many leaders recommended a Christian counsellor instead of mental health services.

This research suggests that church leaders provide a unique relationship for congregants, offering social support and hope. The implications of these findings for psychologists, mental health services and church leaders are discussed and recommendations for future research are made.

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## **CHAPTER ONE: INTRODUCTION**

### **1.1 OUTLINE OF THE CHAPTER**

This chapter reviews the literature regarding mental health, religion and the church. The focus of the review is on the relationship between religious beliefs, church attendance and mental health. The chapter also explores the role of Christian church leaders in supporting individuals with mental health difficulties, with a focus on how and why the support is given. Barriers preventing effective cooperation between the church and mental health services in the UK are discussed. Finally, recent policy regarding the integration of spirituality within mental health services is briefly considered.

### **1.2 HOW THE LITERATURE REVIEW WAS CONDUCTED**

A literature review was conducted using databases and search engines to explore the research relevant to the proposed study. These were OvidSP (Psychinfo, Psycharticles, EMBASE), ATLA (American Theological Library Association) and Google Scholar. The key search terms used were: “mental health and (lead\* or minist\* or clerg\* or pasto\* or vica\* or priest)”, “Church and mental health”, “social support and religion”, “Psycholog\* and religion”, and “pastoral and mental health”. These terms were truncated to increase likelihood of search hits. The largest search returned 3307 papers (“Church leaders and mental health”). To reduce the number of papers in this search, only papers published between 1970 and 2010. The smallest search was ‘social support and religion’ (254 papers). When the option of searching for ‘related articles’ was available on the search engine, this was also taken.

When the journals from the searches were reviewed, pertinent references were taken from the article and accessed. Service related documents were accessed via the websites of the Department of Health and the Welsh Assembly Government.

Due to the breadth of research in the area of psychology and religion some restrictions were placed on the literature review. On the whole, research sampling working age adults was reviewed. The evidence base regarding children and spirituality (e.g. Barrett *et al.*, 2001) adolescents (e.g. Dew *et al.*, 2008) and older adults (e.g. Kirby *et al.*, 2004) was not examined. The papers reviewed focussed on mental health; therefore, the research regarding the impact of religion on physical health was not discussed (see review by Koenig *et al.*, 2001 for more details on this topic).

The question raised by this research represents a tension between psychological and theological understanding of lived experience. In order for this research to be useful to clinicians a degree of explanation regarding the theological underpinnings of Christianity was considered necessary within the literature review. It was thought that some of the Christian concepts and expressions may be unfamiliar to the reader and that the context within which these arise needed to be discussed.

Furthermore, as this area is under researched there are implications for the literature review and the discussion. Whilst the interaction between psychological and theological frameworks produces many relevant overlaps it does not produce a structure that fits both into a neat system. Therefore, although psychology and theology “have much to say to each other, they are different in their aims and methods, so that discontinuities between the fields will always be present” (p.vi, Nelson, 2009).

### **1.3 DEFINITION OF RELIGION**

Religion can be understood as the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals (King & Dein, 1998). However, some argue that religion contains so many unrelated variables it cannot be considered as a uni-dimensional concept in research (Dittes, 1969). Furthermore, people in society are developing a well-documented tendency to describe themselves as ‘spiritual but not religious,’ which is thought to reflect a “postmodern phenomenon involving the privatisation and individualisation of certain aspects of religion” (Collicutt, 2011, pp.250). Spirituality is also considered difficult to operationalise. Spilka’s review (as

cited in Moberg, 2002) concluded that understandings of spirituality are either God-oriented, worldly-oriented with stress on ecology or nature, or humanistic with stress on human potential or achievement.

The present research will focus on the beliefs and actions of Christian church leaders. The author appreciates the broader concept of spirituality and does not presume that those who do not belong to a recognised, religious faith have no spiritual discernment or need (Speck, 1988). Indeed, in this area of research, both spirituality and religion are often subsumed under 'religious', or used interchangeably (Moberg, 2002).

#### 1.4 CURRENT RELIGIONS IN THE UK

In the 21<sup>st</sup> century, religion remains an integral part of many people's lives. Table 1 shows results from the 2001 census, (Office of National Statistics, ONS, 2001) listing which religions people in England and Wales identify with. (It does not include those who did not state a religion. In England and Wales this included 4, 010, 658 people and in Wales alone 234,143 people).

**Table 1: The religions people in the UK associated themselves with (ONS, 2001)**

	Total population	Christian	No religion	Muslim	Other religion	Hindu	Buddhist	Jewish	Sikh
<b>England &amp; Wales</b>	52,041,916	37,338,486	7,709,267	1,546,626	150,720	552,421	144,453	259,927	329,358
<b>Wales</b>	2,903,085	2,087,242	537,935	21,739	6,909	5,439	5,407	2,256	2,015

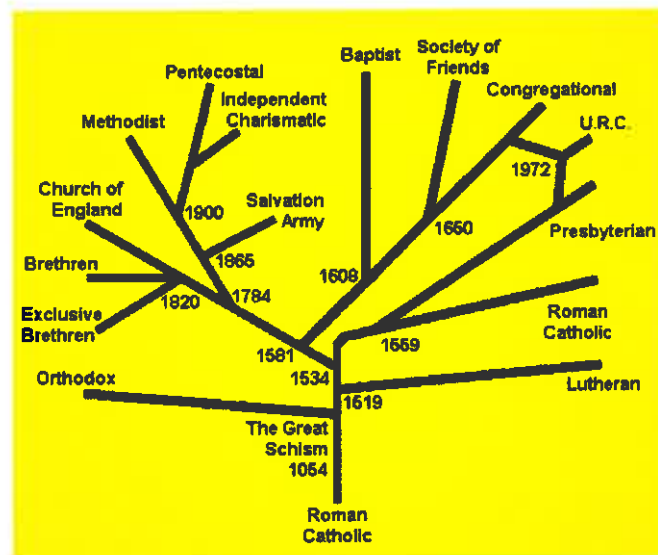
Table 1 columns are ordered from left to right, according to the highest to lowest prevalence of religions in Wales. It can be seen that both in the UK and in Wales, Christianity is the religion most people identify with, and hence is the focus of this research and literature review.

## 1.5 CHRISTIANITY IN BRITAIN

### 1.5.1 Christian denominations in the UK

Around 8% of the UK population attend church regularly (Brierly, 2000), which is considerably less than the 71.7% who professed to Christianity in the 2001 Census. Over the years the Christian faith has branched into many groups, each known as a denomination, which can be defined as “a recognised, autonomous branch of the Christian church” (Oxford Dictionary, 2011). Figure 1 describes this in more detail:

**Figure 1.1: The History of the Emergence of Christian denominations in the UK (Re:Quest, 2007)**



‘Independent charismatic churches’ will be referenced to as non-denominational churches in this paper.

### 1.5.2 The shared tenets of Christianity

Although there are numerous denominational expressions of Christianity, those mentioned in the diagram share most of the same tenets. Recognised, mainstream Christianity can be summed up by the ancient Creed of AD381 (the Nicene-Constantinopolitan Creed, see Appendix 1) which was chosen as a “focus” of the faith (World Council of Churches, 1996).



The Nicene Creed confesses belief in one God who is Father, Son and Holy Spirit and referred to as the Trinity. The Holy Spirit is thought to be the presence or “the life force of God”, understood from the Hebrew term for spirit used in the Old Testament, “ruah”, meaning breath, or ‘life force’. The Holy Spirit gives the believer new life in Christ, characterised by a variety of spiritual gifts (such as peace and goodness) and enables the believer to experience a personal relationship with God. Christians also believe that the Holy Spirit inspired the Bible which is the ultimate source of Christian belief (World Council of Churches, 1996).

A Christian view of personhood begins with the assumption that the world was once flawless, but then human rebellion, or sin, tainted all of creation (McMinn, 2006) and alienated us from God. ‘Sin’ refers to both “acts of transgression, a nature or disposition and a force in opposition to God ... It is both a violation of law and a violation of a relationship” (Jones & Butman, 1991, pp. 50-52).

A further key part of the Christian faith is redemption. There are various theological theories as to how God’s redemption occurs, but all mainstream Christian views centre on the person and work of Jesus, whom Christians deem to be the Messiah (McMinn, 2006). The doctrine of grace, intrinsically linked to the doctrine of sin, teaches that God forgives humans of their sin and offers unmerited kindness and love to whomever acknowledges a need for redemption (McMinn, 2006). Christianity is ultimately based in hope, because of the belief that a loving Creator is always working to restore and redeem that which has been tainted by sin. Christians believe that grace is not only a divine occurrence, but something that should also be extended from one human to another. Another defining feature of the Christian faith and of God Himself is ‘agape love’. This is an ethic of relating to others with the divine love that God has granted us (Nygren, 2007) and is fundamentally relational (McMinn, 2010).

## 1.6 THE RELATIONSHIP BETWEEN RELIGION AND MENTAL HEALTH

In general, research has found religion to be associated with better mental health, such as lower levels of depression and anxiety (Koenig *et al.*, 2001, Plante & Sharma, 2001). These quantitative findings are also supported by qualitative research. In 1997 the Mental Health Foundation conducted the first national user-led survey of its kind, "Knowing Our Own Minds" (Faulkner, 1997) and found that over half of service users had some form of spiritual belief and that these beliefs were positive and important to them in terms of their mental health. Faulkner & Layzell (2000) asked service users to describe the role spiritual and religious beliefs and activity had in their lives. The themes that emerged included the importance of guidance; a sense of purpose; comfort; grounding; the allowance of expression of personal pain and the development of an inner love and compassion for others. All of these were regarded as positive for their mental health.

The positive association between religion and mental health has not consistently been found in quantitative research. The various definitions of the terms 'religion' and 'mental health' used in the literature are likely to contribute to this inconsistency (Lowenthal, 2000). In 1983 Bergin conducted a meta-analysis of 24 published studies on religion and mental health from 1920-1980. He found a mean correlation of 0.09 between religiosity and mental health concluding there was "little positive information for incentive or further inquiry" (p.176). Bergin blamed the bland results on the limitations of measurement and methodology, such as the vast range of clinical and religiousness measures used.

The most recent meta-analysis on the relationship between mental health and religion was conducted by Hackney & Sanders (2003) using 35 studies from 1990-2001. They too criticised previous research for the lack of specificity in the operationalisation of both 'religion' and 'mental health' and considered that both the positive and negative correlations identified in other studies could be explained by this. Consequently, Hackney & Sanders (2003) imposed strict criteria on the studies

included<sup>1</sup> and found an overall relationship between religiosity and mental health ( $r=0.10$ ), similar to Bergin (1983). As the research is correlational in nature, causation cannot be inferred. In this area there is reliance on quantitative research and in trying to isolate the impact of one activity upon another; the rich and complex interactions of other factors may be missed.

Mechanisms that may link religiousness to positive mental wellbeing range from behavioural mechanisms (spirituality may be associated with a healthy lifestyle), social mechanisms (religious groups provide supportive communities for their members), psychological mechanisms (beliefs about God, ethics, human relationships, life and death) and physiological mechanisms (religious practices elicit a relaxation response) (Mohr & Huguelet, 2004). It is noteworthy that many religions and religious participants consider the connection with the Divine as the mediating effect on mental health (Cornah, 2006). Some of these mechanisms will be explored below.

## **1.7 PSYCHOLOGICAL BENEFITS OF RELIGIOUS COMMITMENT**

### ***1.7.1 Religious coping***

One potential mediator in the relationship between religion and mental health is religious coping. This has been operationalised as “the use of religious beliefs or behaviours to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances” (Koenig *et al.*, 1998, p.513).

Religious coping has been explored in a number of ways (Harrison *et al.*, 2001). Some studies have used large surveys measuring frequency of church attendance as a measure of religious coping. For example, some have used a single measure of religious coping, for example, asking an individual whether religious coping was ‘not at all involved’ through to ‘very involved’ in coping with a particular event. Pargament, *et al.* (2000, p.521) state “it is not enough to know that an individual

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<sup>1</sup> A strict inclusion criterion was employed. For example, only studies which had used Pearson’s correlation for analysis and used psychological adjustment as a variable were included. Those which included major clinical disorders as a measurement of mental health difficulties were not.

prays, attends church, or watches religious television. Measures of religious coping should specify *how* the individual is making use of religion to understand and deal with stressors". Therefore, psychometric scales have also been designed to measure the prevalence of religious coping strategies and have enabled coping to be divided into positive and negative coping (Pargament *et al.*, 2000).

Positive religious coping rests on having a sense of spirituality, a secure relationship with God, a belief in life's meaning, and spiritual connectedness with others (Pargament *et al.*, 1998). Positive coping includes trying to find a lesson from God in the event, seeking spiritual support, and providing spiritual support to others (Pargament, 1997). Pargament *et al.*, (1990) found that positive religious coping leads to better mental health outcomes and lower rates of depression in response to significant negative life events.

Pargament *et al.* (1988) found that religious beliefs and practices may guide an individual in the process of selecting solutions to problems, such as how to manage mental health difficulties. Pargament *et al.* (1988) described three styles of problem-solving based on an individual's relationship with God, coined 'collaborative', 'deferring' and 'self-directing'. These act like a "locus of responsibility for the problem-solving process and the level of activity in the problem solving process" (p.348) which could be used to gain control over a situation. The collaborative style is when an individual chooses to solve the difficulty through a partnership with God; the deferring approach is when the individual passively waits for God to take control. The person employing a self-directing style uses their own initiative rather than help from God and has an internal locus of control and active problem-solving (Pargament *et al.*, 1988).

In 2004 Fabricatore *et al.* conducted a prospective study in which undergraduate participants described how they utilised religious coping to deal with life stresses. Using structural equation modelling they found that collaborative and deferring styles of coping were differentially linked to mental health. In line with Pargament *et al.* (1997) it was found that collaborative styles generally led to favourable mental health outcomes, including reduced mental distress. Deferring and self-directing styles were

associated with reduced positive affect and life satisfaction when faced with major life stressors; however the findings were mixed. The strength of this study was its prospective design which can comment more on **causality**, which the majority of cross-sectional studies in this area are unable to.

### **1.7.2 Negative religious coping**

There is some evidence to suggest that certain types of religious coping are linked to greater distress, at least in the short term. For example, an individual who appraises the difficulty they are facing as a sign that God is punishing them, or as having a demonic cause, is likely to feel more distressed (Pargament, 1997; Pargament, *et al.*, 1998). In addition, if an individual expresses confusion and dissatisfaction with God ('spiritual discontent') or the congregation or church leader ('interpersonal religious discontent') this is also seen as negative religious coping. Negative religious coping has been found to result in negative mood, lower self-esteem and greater anxiety when coping with a major negative life event like illness, death of a close friend or relationship problems (Pargament, *et al.* 1998).

Yarbinger-Hicks (2004) examined coping styles in 174 American people recovering from severe mental illness. Participants were asked questions about their mental state, their religious beliefs, (including the extent to which they base important decisions in life on religious faith), religious delusions and religious problem-solving techniques. The authors found that exclusive reliance on self-directed religious coping (see 1.7.1.) was associated with poorer outcomes in relation to recovery. They concluded that spiritual or religious beliefs could affect an individual's attributions or their locus of control perceptions, which in turn could impede recovery.

A meta-analysis was recently conducted to explore the relationship between religious coping and psychological adjustment (Ano & Vasconcelles, 2005). After reviewing 49 studies it was found that negative religious coping strategies were positively associated with negative psychological adjustment to stress. One possible explanation for this finding is that negative religious coping represents a burden for people undergoing stressful situations.

Research in the area of religious coping has attracted much methodological criticism. For example, most studies ask participants to report retrospectively on the coping strategies they utilised but still use current mental health status as the outcome measure. Nonetheless, the findings do indicate that the benefits of religious belief are idiosyncratic and differ according to how they are interpreted and assimilated by the individual.

## **1.8 PSYCHOLOGICAL BENEFITS OF BELONGING TO A CHURCH CONGREGATION**

As mentioned previously, religion can be understood as the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals (King & Dein, 1998). Although beliefs and values can be held by the individual, research has found additional psychological benefits for those who belong to a church congregation. Loewenthal (1995) described several ways in which attending a church could provide support including; protecting people from social isolation, providing and strengthening family and social networks, providing individuals with a sense of belonging and self-esteem, and offering spiritual support in times of adversity. The benefits of church attendance will now be explored.

### ***1.8.1 Social support***

Social support has been shown to be positively associated with psychological well-being (e.g. Myers & Diener, 1995). Conversely, a lack of social support has been linked with greater levels of depression and psychological distress (Buist-Bouwman *et al.*, 2004). The social support that individuals receive from members of congregations and church leaders is deemed to be one of the key mediators between religion and mental health (Hill & Pargament, 2003).

VandeCreek *et al.* (1999) found that religious support emerged as a significant predictor of psychological adjustment after controlling for the effects of general social support. Although this research was specific to families of patients undergoing

cardiac surgery it suggests there is something unique regarding religious support. Lazarus & Folkman (1984) assert that social support cannot simply be defined quantitatively, but must also be contextualised in light of the type of support and the quality of experienced relationships. Fiala *et al.* (2002) divided religious social support into congregational support, church leader support and support from God. Each of these will be discussed below.

### **1.8.2 Congregational support**

People belonging to a church congregation can rely on “the assistance of a group of like-minded individuals who share a set of values and a worldview” (Hill & Pargament, 2003, p.69). Congregations are also sources of companionship, community and belonging (Ventis, 1995). Some members of congregations describe a coping resource, feeling cared for and that they belong (Maton & Wells, 1995). Congregational support can also provide assistance with integrating with the wider UK community. Robinson (2000) found that for African and Caribbean people there is evidence that involvement in religious activities helps reduce the impact of racism and inequality. Furthermore, it was found that those who attend church may recover better from illness and fare better in British society.

However, Fiala *et al.* (2002) criticised studies that have examined congregational support for oversimplifying conceptualisations, for example, rather than measuring religious support directly, inferring support from church attendance. Fiala *et al.* (2002) argues that one cannot assume that a given amount of attendance guarantees an amount of congregational support. Therefore, he validated a 21-item religious support scale, containing three sub-constructs (i.e., God, congregational and church leader support). It was found that congregational support operationalised in this manner was correlated with decreased depression and increased life satisfaction. Church leader support was also related to greater life satisfaction and less depression, supporting previous findings (Koenig *et al.*, 1992). Both congregational support and church leader support was positively associated with church attendance. Unsurprisingly, there is additional evidence suggesting that an

individual who experiences discontent with their religious community can have higher depression scores (Ano & Vasconcelles, 2005, see also 1.7.2).

### **1.8.3 Church leader support**

As well as accessing varying levels of support from the congregation a congregant may also access support from the church leader. Baker (2010) interviewed 8 Christian mental health service users in the UK and found a theme of sanctuary embodied in other people, such as priests. The relationships with leaders were described using the metaphor 'family', denoting security and caring relationships. Research by Foskett *et al.* (2004a) recognised that spiritual leaders in the UK provide much support for those using mental health services. The research known as 'The Somerset Project' was an evaluation of a spiritual and religious service which developed when major psychiatric hospitals in Somerset had closed. A detailed consultation involving service users, professionals and local religious groups was held. As a result, a chaplain co-ordinator was instated in each locality to provide a link between religious groups (including their counselling services) and mental health units and professions. Three research studies emerged in 2000 from the project which will be referred to at a later point. One focussed on mental health professionals, one on religious and spiritual leaders and one on service users. Foskett *et al.* (2004a) noted that the sample involved in the project contained only a third of those who might have contributed, and hence may have constituted a biased sample due to a special interest in this area and may not be representative of their professions.

### **1.8.4 Support from God**

Some theorists have compared God to an attachment figure (Kirkpatrick, 1999) with whom Christians feel they can have a relationship. Attachment theory suggests that children look to their parents for protection; it is thought that people can look to God as a secure base who offers care and protection in times of stress (Hill & Pargament, 2003). Consistent with the predictions made by attachment theory, people who report a closer connection to God experience less loneliness, independent of other



sources of social support (Kirkpatrick, 1999). Fiala *et al.* (2002) found that those who reported more support from God experienced **less** depression and more life satisfaction. Similarly, Mayers *et al.* (2007) interviewed Christians in the UK with mental health difficulties and found that a relationship with God was quoted as a consistent source of strength that underpinned coping. Using a similar sample, Cutland (2000) found that attachment to God and belief in his benevolent control was central to a range of aspects of faith that were perceived to facilitate coping. It appears that the quality of an individual's perception of their relationship with God is an important factor in psychological well-being.

### **1.9 CHRISTIAN HELP SEEKING FROM THE CHURCH**

A UK survey of over 1000 people found that 17% of people in the UK would seek a religious leader for help with emotional difficulties, in comparison to 16% who said they would go to a 'mental health professional' (Barker *et al.*, 1990). The researchers recognised the cultural and contextual influence that leads psychological help seekers in multiple directions, not just to mental health services. The cultural context impacts on both the perception of the problem and ways of dealing with it. Notably, the number of people who claimed they would seek help from religious leaders could have been underrepresented as the questionnaire used the word 'priest', and many denominations do not call their church leader a 'priest'.

### **1.10 CLERGY PROVIDING PASTORAL CARE FOR INDIVIDUALS WITH MENTAL HEALTH DIFFICULTIES**

"One woman was relieved at a point of much personal distress because a clergyman made her feel less guilty. She and at least one other just appreciated a minister 'being there' when they had been in distress. One talked about receiving counselling from her minister who had been useful and one was grateful that a lay-preacher had listened to her doubts ... In some cases the priest had been so supportive that they were seen as a friend" (Nicholls, 2002, p.36).

Historically, the medieval church considered looking after the 'insane, poor and deprived' as a Christian responsibility. Hence, Bethlehem hospital, ('Bedlam') opened in 1247 as a monastery and started to receive people considered 'lunatics' in 1377 (Sims, 2006). In 1601 the Poor Law was introduced and stipulated that it was the responsibility of every church parish to support those who were unable to look after themselves (Mind, 2011). In 1808 the 'County Asylums' Act' gave powers to the Justices of each county to build asylums and in 1875 the government began to pay a subsidy to the poor law authorities towards supporting 'pauper lunatics' in asylums, hence, transferring some of the responsibility for those with mental health difficulties from the church to the state (Mind, 2011). Until the mid-1950's asylum care was the routine approach to managing mental illness in the UK. Deinstitutionalisation moved care back to the community, which was supported by the dramatic closures of mental health inpatient wards in the 1980's (Turner, 2004).

The movement of psychiatric care from institutions to the community means faith leaders now meet more people with psychiatric difficulties. Often faith based organisations are the first port of call for distressed individuals, particularly in some ethnic minority communities (Cinnirella & Loewenthal, 1999, Leavey, 2008). Yet the issue of how people with mental health difficulties within the church are supported has been given scant attention by researchers (Weaver *et al.*, 2003).

In both psychological and theological circles the type of care provided by church leaders or clergy is known as pastoral care. The *cura animarum*, or care of souls, as pastoral care was described in the past, has been a key feature of Christian communities from the earliest times (Pattison, 2000). A 'Pastor'<sup>2</sup> is a shepherd who looks after his flock and early Christian leaders adopted the term as a way of capturing the need to guide, heal and sustain the community (Pattison & Woodward, 2000). The key element that separates religious pastoral care from secular pastoral care is:

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<sup>2</sup> Some church leaders are called pastors. Leaders in the Roman Catholic tradition are called 'priests' and leaders in the Anglican tradition are known as 'Vicars'.

“A transcendent reality, which is often lacking in a **secular** situation of pastoral care, and a conviction that the path to wholeness is not purely of human endeavour and human interaction” Wright (1980, p.9).

### **1.10.1 Pastoral counselling**

Many clergy describe part of their pastoral work as providing counselling. Leavey (2008) defined counselling as ‘activity or intervention giving guidance and advice on a personal basis with the aim of relieving emotional pain’. Leavey (2008) found that counselling was offered by the majority of clergy and was articulated within a religious framework. Weaver *et al.* (1995) found that church leaders in the UK can spend an average of 15% of their 50 hour week in pastoral counselling. However, in the UK little is known about the pastoral role of the church leader when working with people with mental health difficulties. Leavey *et al.* (2008) explored the barriers and dilemmas for clergy in caring for people with mental illness. They interviewed 32 male clergy from a variety of faiths (including Christian ministers, rabbis and imams) mostly based in London. They found that substantial support and comfort was provided by these clergy at times of crisis or loss. Leavey *et al.* (2008) also found that non-spiritual explanations of mental illness predominated in interviews with white mainstream ministers, whereas spiritual explanations were more likely with black Pentecostal ministers (see 1.11.1 for more examples).

In some ways the pastoral relationship could be considered similar to the psychotherapeutic relationship. Lampropoulis & Spengler (2005) compared ‘religious interactions’ (such as pastoral care or religious counselling) with psychotherapy, and described two important advantages religion has as an intervention: (a) The perception of divine presence can greatly enhance the helpee’s expectations for change, and (b) it is based on theistic systems well organised to provide their services through the lifespan. Although individuals feel it is the blend of counselling and religious teaching that helped them, research has found that religious based therapy provided by non-religious mental health professionals is also effective (Propst *et al.*, 1992).

There has been an increase in the number of outcome studies examining psychotherapies that incorporate religion and spirituality into therapy (Hook *et al.*, 2010), such as Christian cognitive therapy for depression or Muslim psychotherapy for anxiety. These are referred to as religious accommodative therapies. Worthington *et al.* (2011) meta-analysed 46 studies examining the outcome of religious accommodative therapies. Religious clients showed greater improvement in religious psychotherapies, than those in alternate secular psychotherapies, on psychological and spiritual outcomes. However, this research area is in its early stages so there is not a lot of research to base conclusions on at present. Also, therapist allegiance was an issue in the studies as many of the therapists may have been biased towards the therapy working, especially as some were also the main researchers. Furthermore, the research did not describe what psychological or spiritual outcomes were measured. Indeed, lack of specificity has been a general criticism of this area of research. Nonetheless, a therapy that could accommodate religious beliefs may impact a religious individuals' willingness to seek help from secular sources, or their engagement with the therapeutic process.

#### **1.10.2 Pastoral care**

Leavey (2007) conducted in-depth interviews with UK Christian, Muslim and Jewish clergy in the UK, and found that the personal history of the church leader, training and attitude to role resources in the faith community were often organising factors in the type of pastoral support provided. This varied within and between faith groups. Supporting individuals with enduring mental health difficulties was relatively infrequent, but where it occurred individuals were typically 'known' by the clergy and had been supported for a significant period of time. Other leaders knew the congregant had problems but were unsure of the diagnosis. Amongst the sample of clergy were three who had trained as doctors, two trained as nurses, and others with psychiatric chaplaincy experience or training in counselling.

In addition, Leavey (2008) suggested that pastoral care could be divided into four approaches. The first is an 'inclusionist' approach where concern about social isolation of the mentally ill is foremost and a place within the community is made. Care rather than cure is prominent. The second form of pastoral approach is

'counselling' (see 1.10.1) which is underpinned or articulated within a religious framework and also includes prayer and healing in private. The third type is 'pedagogic' where scriptural teaching is used in tandem with counselling to provide guidance for correct living and as a preventative measure facilitating 'good mental and physical health'. The Christian clergy argued that the philosophical framework of Christian teaching can facilitate health through religion-inspired coping.

The final type is 'prayer and healing ceremonies'. The mentally ill person was assessed for spiritual problems and treated either by spiritual healing, prayer and, when the problem was deemed to be due to demonic possession or oppression, through exorcism or deliverance ceremonies. This was found more with Pentecostal clergy than Catholic or Anglican clergy.

One difficulty with this research is that very few quotes are provided so it is difficult to ascertain how grounded in the data it was. However, this is one of few studies examining the type of pastoral care provided by religious leaders in the UK. Leavey's (2008) conclusion was that pastoral care follows no particular model and is provided according to the particular skills, interests and energies of the individual clergy and whatever human resources are on hand. Some of the other types of support provided by churches will now be briefly explored.

### **1.10.3 Prayer**

Ameling (2000) defines prayer as "a simple act of turning our minds and heart to the sacred" (p. 42). The majority of religious traditions encourage prayer, although there are many differences in style and technique. **Regardless** of the faith tradition, the aim of prayer is to communicate with the sacred and divine (Plante, 2008). Prayer can also be used as part of healing practices within church, including meditation, speaking in tongues, anointing with oil and the laying on of hands (McGuire, 1988). Prayer has been found to result in many benefits such as improved psychological functioning, a sense of well-being and meaning, stress reduction and better coping (Masters, 2007). Prayer is practiced both by the individual with faith and used by leaders in a congregational setting and in individual pastoral settings.

#### **1.10.4 Facilitating community**

Leavey *et al.* (2008) described the way in which care was approached in churches as 'inclusionist' and driven by the concern about the social isolation of the mentally ill. Leaders who adhered to this considered those with mental health difficulties to be within the religious community for care rather than cure. Leavey (2008) found that clergy who live in deprived areas seem most aware of the need for inclusion. Church was seen as a haven for vulnerable people because it was an 'accepting place', offering fellowship that can help individuals cope with their problems and eliminate marginalisation. Leavey (2008) discovered that the clergy encouraged individuals with mental health difficulties to be involved in church ceremonies and duties as this was considered therapeutic.

This concurs with the qualitative data recorded in the Somerset Spirituality Project (Nicholls, 2002). Many service users interviewed found the company and support of others from the same faith helpful:

"I mean I have become fairly OK at looking after myself and I have such a lot of people in the Church that support me and would worry about me if they didn't hear from or see me that I suppose I am not in as much danger... as some people might be... I don't know what I would do without them really"(p.35).

Research has found that both clergy and religious communities can provide a sense of support and continuity before, during and after treatment for mental health difficulties (Pargament & Maton, 2000; Shifrin, 1998). Many clergy know multiple generations within a family and officiate at important events throughout their lifespan (e.g. christening, weddings etc.; Milstein *et al.*, 2003) placing them within a unique role within the community.

### **1.10.5 Supporting those who are bereaved**

When individuals do not attend a church they are likely to encounter church leaders at times of terminal illness or bereavement. Milstein *et al.*, (2010) described clergy as 'de facto experts on the normative course of bereavement' due to their regular experience of conducting funerals and visiting those who are grieving. However, Lloyd-Williams *et al.*, (2006) found that many clergy were not, in fact, experts on bereavement. They sent a questionnaire to 125 Christian clergy working in Sheffield to assess what skills and knowledge clergy believed they had in this area. A subsidiary questionnaire was sent to 42 clergy training colleges to evaluate the teaching offered. There was a trend across all denominations (Anglican, Methodist and Baptist) for those who had trained more recently to have received relevant training. Most clergy believed that they possessed adequate liturgical skills, but 13% felt they possessed little or no skill in the pastoral care of the dying. Seventy-one percent indicated that they would like further training in pastoral care of the dying and 66% desired training in care of the bereaved. Of the 50% of training colleges that responded, the number of hours of training on pastoral care of the dying ranged from 6 to 36 hours and only 26% believed that their training in pastoral support skills was comprehensive. Thus, although clergy regularly encounter the bereaved, it is doubtful they feel equipped to do so.

## **1.11 FACTORS INFLUENCING THE TYPE OF SUPPORT CHURCH LEADERS PROVIDE**

There is minimal discussion in the literature about how church leaders' views shape their decisions about mental health referral and intervention (Payne, 2009) except in relation to their views on the aetiology of mental health difficulties. A brief overview of some of the research in this area will be given.

### **1.11.1 Explanatory model of mental health difficulties**

An explanatory model encompasses a person's ideas about the nature of the problem, its cause, severity, prognosis and treatment preferences (Kleinman, 1980). However, some research has attempted to describe the explanatory models of a selection of laypeople such as first time presenters to mental health services. It was

found they held explanatory models that did not consist of a coherent set of beliefs, rather several explanations were held simultaneously, or taken up and dismissed rapidly (Williams & Healy, 2001). However, little research has been conducted on the models held by Christian church leaders (Mathews, 2008).

A church leader's understanding of mental health difficulties will influence both the congregant as an individual and the congregation at large. Consequently, the author considers it important to understand how Christian leaders believe mental health problems occur and how best to support individuals suffering from such problems, because the beliefs held by the leader can have a powerful impact on the congregation. Stanford (2007) surveyed 293 Christians in America who had friends or family members with mental health difficulties. It was found that 32% of those people were told by their church leader that their loved one did not have a mental health difficulty but the cause was purely spiritual in nature. This experience weakened the faith of 15% of the sample and 13% said they were no longer involved in the faith because of it. Church leaders maintain a powerful position over groups of people; their thoughts are taken seriously by congregants, especially those with mental health difficulties who may feel in a vulnerable state. The study was an anonymous online survey and the denomination and theological ideologies of the churches attended were not enquired after. It is also important to consider the 68% who were not told that the mental health problem was spiritual in nature.

The impact leaders' and congregants' explanatory frameworks can have on service users was researched by Baker (2010). He interviewed Christian mental health service users regarding their experiences of interacting with people in Church and in mental health services. The analysis suggested service users had encountered two explanatory frameworks that other congregants held. One was that mental health difficulties were caused by controlling spiritual forces. The second attributed mental health difficulties to laziness, or lack of will power. Recovery was therefore deemed to be the responsibility of the participant. Some participants found that the explanations given for mental health difficulties in church differed from those provided in mental health services, or were incongruent with the individual's own views. Participants also described how, when their needs exhausted the explanatory



model, instead of those in church developing a more adequate model, they were rejected from the church.

Lowenthal (1996) found that amongst Christians there are views of mental illness being caused by separation from God and demonic possession. These beliefs might arise from the numerous accounts in the bible of Jesus healing people of illnesses caused by demonic possession (Hartog & Gow, 2005). To some clergy the concept of illness produced by a beneficent God is incomprehensible. Therefore, among clergy with a more dualistic worldview, only goodness can come from God and the devil is always the source of sickness and suffering. "Such dualistic beliefs form the basis for a readiness to assume a malign supernatural presence in mental illness and therefore the need for clergy in such intervention" (p.575, Leavey, 2010).

The dominance of a spiritual explanation for mental health difficulties is often researched according to denomination. Payne (2009) found that American Pentecostal ministers and non-denominational pastors were much more likely to agree with statements about the spiritual cause of depression than American mainstream Protestants. Stanford (2011) interviewed 168 senior Baptist pastors who perceived biological causes as more important than psychosocial or spiritual causes. However, there was variation with respect to the diagnosis being discussed. A spiritual explanation was most likely when discussing depression and anxiety.

Leavey (2010) conducted a qualitative study of 19 clergy in the UK and interviewed them regarding their beliefs and attitudes to supernatural explanations for mental health. The clergy considered that demons or spirits 'entered' an individual through mental and physical illness; or was passed down to an individual through generational or ancestral misdemeanours and misfortune. Amongst Pentecostals and those on the evangelical side of mainstream Christianity the relationship between sin and poor health was a direct one. The Health Education Authority, in *Promoting Mental Health* (1999), notes that vulnerable people may be distressed by a focus on demons as a cause of illness, but states 'some people have found exorcism and similar approaches helpful' (cited in Gray 2001).

Mathews (2008) found that several different models were held by Christian clergy to explain mental illness. He surveyed 215 clergy concerning their beliefs regarding the aetiology (incorporating a lack of obedience to scripture, an individuals' failure to have their minds renewed by God's word, a lack of spiritual disciplines and the presence of sin) of mental health difficulties. Using factor analysis he found that a traditional Christian view of aetiology was most endorsed. Such explanations focused on the individual's lack of responsibility in maintaining Christian thoughts and behaviours. Mathews emphasised how, in addition to the Christian view of aetiology, nearly half of the clergy population complemented this belief with a mixture of psychological or organic models. This research was conducted in Singapore so how generalisable the results are to the UK is unknown.

With several explanations of mental health difficulties available to church leaders Foskett (2001b) found that some church leaders remain loyal to their religious and theological roots, some are drawn to one of the many psychological perspectives and others, in their suspicion of both psychological and religious perspectives explore care from the experience of the cared for (Pattison, 1994). Leavey *et al.* (2008) suggested much more research is needed on the needs of UK church leaders, their explanatory models and the type of pastoral care that they are able and willing to give.

### **1.11.2      *Leader's wariness***

Another factor which could influence the type of support that leaders offer those with mental health difficulties is their wariness of people with mental health difficulties. Leavey *et al.* (2007) interviewed UK based clergy and some talked about their fear of individuals with mental health difficulties being unpredictable or violent. Consequently, the clergy responded to individuals with caution or at times, rejection. Only the clergy who had personal-familial experience or professional training had a more relaxed attitude. This is in contrast to Gray (2001) who conducted research involving a UK congregation and did not find evidence of stigmatising attitudes towards people with long term mental illness. However, the need to assess risk of

dangerousness was highlighted as a major concern. Gray (2001) found that the church congregants also found those with mental illness 'hard to talk to'.

### **1.11.3 Leaders' lack of training**

It could be presumed that church leaders would receive some element of training on the cause and the best type of support for individuals with mental health difficulties and that this would influence support given in churches. More established denominations such as Anglican, Methodist and Baptist do provide bible schools which offer theological and pastoral training. However, non-denominational church leaders often do not attend formal training and come from a variety of educational and cultural backgrounds.

Much research has found that leaders from a range of denominations felt that they lack resources; and felt underprepared and vulnerable when working with those with mental health difficulties (Kramer *et al.*, 2007; Lloyd-Williams, 2006). Leavey *et al.* (2007) found that clergy expressed feelings as though they were not well prepared for working with those with mental health difficulties. Foskett (2004) discovered that religious leaders felt unprepared to understand the medical and psychological aspects of mental ill health and the majority were uninterested in learning more. Other research has found that church leaders had the same amount of knowledge of symptoms of emotional distress as a group of college undergraduates in an introductory psychology class (Weaver & Koenig, 1996). However, in context it is important to bear in mind that the average mental health professional knows little about theology.

Some denominations have recognised the need for further training. In 2003 the Church of England announced:

"The Synod urge parishes and deaneries to develop their pastoral care of those with mental illness and their carers and welcome the decision to produce 'Promoting Mental Health: A Training Resource for Pastoral Care' as a means of equipping them to do so; and commend the ministry of the mental health chaplains in promoting the

wellbeing and needs of mental health users and their carers” (as cited in Tidyman & Seymour, 2004, p.8).

However, whether or not this training occurred in local churches is unknown and provision for leaders of non-denominational churches remains unclear. Nonetheless, church leaders have been described as a ‘cultural’ bridge between the formal healthcare system and recipients of care (Kramer *et al.*, 2007).

## **1.12. INTERACTION BETWEEN MENTAL HEALTH SERVICES AND THE CHURCH**

Foskett *et al.* (2004a) stated that few religious leaders or mental health professionals doubted the relationship between mental health, religion and spirituality but found that integration between mental health professionals and faith communities had “at best been uneasy and at worst non-existent” (p.1). Oppenheimer *et al.* (2004) conducted a search of literature from 1970-1999 to further understand collaboration between clergy and psychologists. They found 144 articles and through conducting a meta-analysis constructed six themes from them including; the lack of recognition of clergy as frontline mental health workers or gatekeepers to the mental health system, obstacles to collaboration, the importance of shared values, the benefits of collaboration for both clergy and psychologists, the role of clergy and mental health professionals in prevention, and the need for education for clergy and mental health professionals regarding each other. Two thirds of articles concluded that clergy needed more knowledge about mental health problems and 20% also established that mental health professionals needed more training about clergy’s work. Unfortunately, the researchers did not state how many of the papers reviewed used UK samples so it is unclear how much these results would apply to the UK. Some of the issues surrounding interaction between churches and mental health services will be explored below.

### **1.12.1 The historical neglect of religion within psychology**

In the past, psychology as a discipline was keen to disengage itself from its philosophical and religious roots in the endeavour to establish itself as a hard science (Pargament & Saunders, 2007). In addition, key figures in the history of psychology such as Freud (1959) spoke against religion, calling it “the universal obsessional neurosis of humanity”. Skinner (1971) believed that behavioural principles, based on rewards and punishments, could explain how the practice of religion impacts psychological functioning. He said, “a religious agency is a special form of government under which “good” and “bad” became “pious” and “sinful”. Contingencies involving positive and negative reinforcement are codified ... and maintained ... usually with the support of ceremonies and rituals” (p.116).

Historically, religiosity or ‘religious receptivity’ (Verhagen *et al.* 2010) was viewed as a variable which could predispose someone to psychopathology. Key areas of research were the impact of religiosity on depression, schizophrenia, anxiety and obsessiveness. One significant finding was that of a difference between intrinsic and extrinsic religious commitment. Allport & Ross (1967) originally suggested that there were two types of religious commitment. One was ‘extrinsic’ religion which was when an individual’s religion is one “of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself” (p.400). This orientation of religious commitment has been found to be correlated with mental health difficulties. The other is ‘intrinsic’ religion which is regarded as a “meaning endowing framework in terms of which all of life is understood” (Donahue, 1985, p.400). A positive connection has been found between this kind of religiosity and measures of mental health (Barker, 2000) (see Appendix 2 for more details).

The context began to change as ‘psychology entered a post-positivistic era and began to explore other paradigms (e.g., positive psychology, eastern psychology) that were more open to religion and spirituality’ (Pargament & Saunders, 2007, p.904). Historically, issues of religion, mental health and culture have been highlighted by psychiatrists and sociologists more than psychologists (Lowenthal & Lewis, 2011). For example, the APA division 36 ‘Psychology of Religion’ was

established over 30 years ago. In 1999 the Royal College of Psychiatrists launched the spirituality and psychiatry special interest group (Culliford, 2011) highlighting the need for spirituality to be considered in mental health and the need for psychiatrists to receive further training in such issues.

By the turn of the millennium psychology began to show an interest evidenced by the emergence of books and journals in the area (Lowenthal & Lewis, 2011). Although the British Psychological Society does not have a spirituality group, psychologists within faith traditions have set up their own interest groups such as the British Association of Christians in Psychology. Furthermore, in April 2011 *The Psychologist* released a special edition focussing on psychology, religion and spirituality.

### **1.12.2 *Mental health professionals' willingness to interact with faith communities***

Research in the UK indicates that psychiatrists and psychologists are less religious than the general population (Neeleman & King, 1993) which is not as true in the US (Roskes *et al.*, 1998). Neeleman and King (1993) surveyed 231 psychiatrists working in London regarding their religious attitudes and beliefs. However, the results suggested that 92% of psychiatrists considered that there are links between religion and mental illness and 'that psychiatrists should concern themselves with the religious beliefs of their patients during assessment and therapy' (p.423). No consistent pattern was found regarding their views about the nature of this association, with some considering religion being better for, and some worse for mental health. The results also suggested that psychiatrists who were religious themselves were more likely to refer patients to religious leaders but in general psychiatrists are undecided about the role of religious and spiritual belief in the development of, or recovery from, mental illness and are reluctant to directly liaise with the clergy and other religious leaders

Fallot *et al.* (2007) sampled UK service users, mental health professionals and religious leader's views through a variety of spirituality and mental health discussion groups. The professionals reported dilemmas with the integration of service users'

religious issues into the context of mental health problems. Integration was something they hoped for but were sceptical about how it would work. Foskett *et al.* (2004) claimed that the lack of interaction between mental health services and religious leaders is unlikely to change until both professions learn more about each other's disciplines and their relevance to the mental health, religion and spirituality of service users (Nicholls, 2002). Foskett (2001b) also found mental health professionals were unsure of how best to cooperate with religious leaders and chaplains, until they get to know them, if they ever got the opportunity to. Leavey concluded that developing collaborative links between mental health services and faith groups is likely to be fraught with complexity and uncertainty (Leavey, 2008).

### **1.12.3 Mental health professionals lack of training**

Weaver *et al.* (1997) have noted the dearth of knowledge regarding mental health issues in the United States amongst mental health professionals there. It was felt that few psychologists have received training to effectively deal with issues pertaining to faith and religious dynamics. Smiley (2001) surveyed 246 psychologists in the UK and found they had no training related to religion either during their clinical course (71.7%) or since qualifying (79.3%). The mean number of days during clinical training engaged with this topic would equate to 1 ½ hours on a UK clinical training course, and 2 ½ hours since qualifying.

### **1.12.4 Church leaders' willingness to interact with mental health services**

A similar reticence to inter-disciplinary working is found amongst Christian leaders. Research from the UK suggests that clergy and religious leaders are uncertain about the relationship between mental health and spirituality, and rely upon the individual with problems to take whatever initiative they want. Foskett *et al.* (2004a) found that 73% of religious leaders did discuss mental health difficulties with their congregants. However, in supporting them clergy fear getting it wrong and making things worse and believe that mental health professionals will know best (Foskett *et al.*, 2001b). At the same time clergy are suspicious that mental health professions are uninterested

in and even hostile to religion and spirituality. Nonetheless, 60% of leaders did refer to GP's but only 30% to mental health professionals (Foskett *et al.*, 2004a).

Likewise, a Christian radio station questioned 513 UK church leaders via a postal survey and found that 30% of leaders considered it very effective to refer congregants to mental health services and 45% thought it would be very effective to refer to Christian counsellors (Premier, 2008). The research, which is currently unpublished, represents a rare large scale UK based survey. Overall, the information was limited by the responses afforded by the questions. The leaders were asked in most instances to respond on a scale from very ineffective through to very effective, most responses were in the very effective/fairly effective range. In addition, the leaders were sampled from the radio listeners list which could represent a bias sample.

#### **1.12.5 Mutual distrust between clergy and mental health services**

Researchers have observed a mutual distrust between clergy and mental health professionals in the United States (Kramer *et al.*, 2007; McMinn *et al.*, 2005) and in the UK (Baker, 2010). It is generally considered that this arises from the perceived lack of shared values between the two communities which prevent interaction between the two. Some of the ways in which a theistic perspective is different from a clinical/humanistic perspective are detailed in Appendix 3 (Bergin, 1980). Clergy also express concern that some mental health professionals might undermine or show contempt for the faith of their clients (McMinn *et al.*, 1998).

Chaplains in some areas of the UK have established links with mental health professionals and report finding it easier to form these than do religious leaders who are not attached to the mental health service (Nicholls, 2002). However, Foskett (2001b) found that neither mental health professionals, nor religious leaders, make much use of the chaplains employed locally and less than a third of mental health professionals regard the appointment of chaplains as a priority in the service. Foskett (2001b) concluded that religious leaders are much more confident in approaching general practitioners and counsellors than they are mental health service staff; this is despite the active policies of outreach and community care by mental health staff.



There are clearly issues which prevent church leaders and mental health professionals from interacting further.

#### **1.12.6 Service users' concerns about the interaction between mental health services and religion**

Service users have highlighted the link between mental health and spirituality and the need for individuals from both sectors to communicate with each other to provide services which appreciate religious and spiritual needs (Faulkner, 1997, Faulkner & Layzell, 2000, Cornah, 2006). However, it seems that service users also have concerns about the church and mental health services interacting. Mitchell & Baker (2000) sampled a UK non-clinical group and found that people with strong religious beliefs had fairly negative views of secular mental health services, fearing that NHS psychologists might be 'anti-religious' (Cutland, 2000). Some researchers have suggested that it is possible that 'the posited steady erosion of spiritual literacy in modern discourse may contribute to the increased isolation in a secular environment of the person with religious/spiritual beliefs' (Mayers *et al.*, 2007, p.325).

Mayers *et al.* (2007) examined how a clinical sample of 10 Christians currently receiving or recently finished psychological therapy (in the UK) understood their psychological problems and how this impacted the help they sought. Participants used their religious beliefs to cope with their psychological problems before and during therapy. Mayers *et al.* (2007) also found that participants anticipated the response of fellow congregants to hearing they had accessed psychological services as either supportive or reproachful. In addition, participants also thought that receiving counselling only from the church could be bad because it was an exclusively spiritual understanding. Conversely, some participants feared that other congregants may judge them seeking secular help as a rejection of God's ability to help, and that God too would judge them. This made going to secular services for help difficult. Nonetheless, the experience of having psychological therapy was perceived as strengthening to faith and part of a spiritual journey. The research was based on a small sample who had a broad range of psychological difficulties, meaning it is not possible to generalise the findings. However, it does highlight

potential themes for individuals with religious beliefs accessing mental health services.

Mutually beneficial collaboration between clergy and mental health services are gaining increased research attention in America (Benes *et al.*, 2000, Milstein *et al.* 2010) but actual efforts are reported to be scarce (Plante, 1999). In the UK, government policy has begun to acknowledge the importance of having spirituality and religion recognised as part of mental health services.

### **1.13 POLICY REGARDING SPIRITUAL CARE IN THE NHS**

The Government in Scotland, England and Wales have written policies regarding spirituality and mental health within the last decade. The Scottish Executive Health Department issued 'Spiritual Care in NHS Scotland' in October 2002. In 2003 the National Institute for Mental Health in England designed a two year programme to develop thinking and practice in relation to spirituality and mental health (Myers & Deiner, 1995). Then in May 2010 the Welsh Assembly Government launched 'The Standards for Spiritual Care Services in the NHS in Wales'. The document defined standards for the acknowledgement of spiritual needs in clients and for the recruitment and development of chaplaincy staff in inpatient contexts. The launch of the document highlights the manner in which spirituality and religion are being recognised as important in both the maintenance of wellbeing and recovery from mental health difficulties. The Welsh Assembly Spiritual Care Standards (WAG, 2010) state that "a written protocol is in place for NHS staff to refer to local faith community leaders and belief group representatives' should be in place". However, little is known about the nature of interactions between individuals in psychiatric distress and local church leaders in south Wales. As research suggests interactions between services and faith communities are limited, it is unclear how this strategy could be implemented. Furthermore, there could be individual differences between clergy causing variation in how willing local faith communities are to engage with NHS services and the type of care they provide for individuals with mental health difficulties.

#### **1.14 RATIONALE FOR THE STUDY**

The literature reviewed within this chapter suggests that, although the evidence is mixed, there are suggestions that religion can be beneficial in helping people to cope with mental health difficulties. The research also suggests individuals with mental health difficulties find it helpful to seek support from church leaders, and the church itself. However, few studies have been conducted in the UK to explore how church leaders support individuals with mental health difficulties. Research would suggest that church leaders in South Wales are likely to be fulfilling this role, but no research has examined whether this is the case. Furthermore, research has explored church leaders' explanatory models for the cause and treatment of mental health difficulties but has found that models held do not necessarily correspond with action taken. It is therefore of interest to explore what other factors could impact the type of support offered by churches.

The Spiritual Care Standards emphasised how 'the uniqueness of Wales and its people needs to be matched by services tailored to their needs' (WAG, 2010). Therefore, exploring the uniqueness of Wales and understanding how to develop good working relationships between mental health services and faith groups in south Wales is important for service development. Especially if the spiritual care standards (WAG, 2010) are to be embedded in services. Few studies in this area have been conducted in the UK; the majority are sampled in the United States, meaning generalising from previous results is often not possible. Consequently, little is known about the challenges and dilemmas church leaders in south Wales face when supporting members of the congregation with mental health difficulties.

Therefore, this exploratory study aims to examine how church leaders support members of their congregation with mental health difficulties and why they do so.

#### **1.15 CLINICAL RELEVANCE**

The researcher aims to provide information relevant for service development and collaboration between mental health professionals and church leaders. In addition,

this research aims to provide information for clinicians working with clients who attend a church about the kind of support they may be receiving within a church context. Moreover, it aims to inform clinicians about themes which may be important in therapy. The process of participation may also allow church leaders participating space to reflect on their practice.

## **CHAPTER 2: METHOD**

### **2.1 OUTLINE OF THE CHAPTER**

This chapter explains the design of the research study and provides the rationale for choosing the qualitative method of grounded theory. The researcher's epistemological and personal position in relation to the research are defined. The manner in which participants were sampled, the procedure followed and the way in which data were analysed are clarified. Furthermore, ethical issues are discussed and the way in which the quality of the research was evaluated is explained.

### **2.2 DESIGN**

A qualitative design was utilised, guided by the principles of the grounded theory approach (Strauss & Corbin, 1990) and applied within a realist framework (Madill *et al.*, 2000; see below for more details). The aim of the research was to explore the understanding church leaders have of supporting congregants with mental health difficulties within the church. In addition, it examined the factors which influence why church leaders support congregants in the way they do. A further aim was to explore the relationship between leader's understanding of mental health difficulties and their use of referrals to professional mental health resources. Data were collected through semi-structured interviews and then analysed. Respondent and colleague validation were employed as credibility checks (Elliott *et al.*, 1999, Baker & Wang, 2004).

### **2.3 RATIONALE FOR USING QUALITATIVE METHODS**

Qualitative research involves an interpretive, naturalistic approach to its subject matter (Denzin & Lincoln, 1998). It can be used to understand complex, interrelated or changing phenomena in terms of the meanings people bring to them (Jones, 1995). In addition, it allows researchers to determine how meanings are formed through and in culture (Corbin & Strauss, 2008).

The type of support for individuals with mental health difficulties within church is under-researched in the UK (Leavey *et al.*, 2007). Therefore, a qualitative approach was considered best to understand how meanings are formed within Christian churches (Willig, 2001, 2008).

#### **2.4 THE GROUNDED THEORY APPROACH**

The grounded theory approach is a qualitative approach to data collection and analysis with roots in symbolic interactionism (Blumer, 1969). This approach was initially presented by Glaser and Strauss (1967) but since its inception the method has continued to develop (Mills *et al.*, 2006). Thus, both original and more recent versions of grounded theory currently co-exist, with Glaser now referring to his own writings as classic grounded theory.

The grounded theory approach is described as a “general methodology for developing theory that is grounded in data, systematically gathered and analyzed” (Strauss & Corbin, 1990, p.23). This suggests that the theories that arise are grounded in the data itself, rather than in “analytical constructs, categories or variables from pre-existing theories” (Willig, 2001, p.32). Analysis and data collection proceed simultaneously, which prompts theory production and development where little theory exists (Corbin & Strauss, 2008), to provide alternative understanding of beliefs and actions (Charmaz, 1990) and to explicate contextualised social processes (Willig, 2008). Therefore, grounded theory can refer to both a method of data analysis and to the product of the analysis.

#### **2.5 EPISTEMOLOGICAL POSITION**

As qualitative research is not a homogenous domain, it is thought that researchers should make their epistemological position clear to the reader (Madill *et al.*, 2000) as this impacts significantly on how data are analysed and understood. Researchers utilising grounded theory have been criticised for glossing over its epistemological assumptions (Charmaz, 1990).

Grounded theory can be utilised within a realist or contextualist framework (Madill *et al.*, 2000). Glaser's (1978, 1998) position was considered to be one of traditional positivism (Charmaz, 2000) assuming an objective external reality, a neutral observer who discovers data and an objectivist reproduction of the data. The researcher subscribes to a critical realist position which contends that 'the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations' (Bunge, 1993, p. 25). Therefore, acknowledging an inherent subjectivity in the production of knowledge.

In adopting a critical realist position the researcher will attempt to remain mindful that categories do not simply emerge from the data, as they did not exist before categorisation by the researcher. Therefore, attention will be paid to reflexivity which is defined as "exploring the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p.228). The researcher will also highlight her assumptions, values, sampling decisions, analytic technique and interpretations of context which have shaped the research (Charmaz, 2006).

## **2.6 RESEARCHER'S POSITION**

The researcher subscribes to the belief that any findings are context specific. It is therefore important to employ reflexivity to consider the impact the researcher's personal and cultural perspective may have on the findings. The researcher was mindful of the role she played throughout the process through the statement of her position (see below), and through keeping a research diary and memos (see 2.9.2).

The researcher is a white, 29 year-old, married female who was employed within the NHS as a Trainee Clinical Psychologist. The researcher comes from a family who follow Christian beliefs and practices and she has attended church since she was 4 years-old. The researcher has been part of many different denominational expressions of church including Roman Catholic, Anglican, Baptist, Pentecostal, and non-denominational churches. Consequently, the researcher considers herself to be

aware of the potential range of expressions of Christian belief and practice between and within denominations.

The researcher had known friends with mental health difficulties who were members of church congregations. Some had felt supported in a manner which appeared to facilitate their recovery and enabled them to maintain a sense of identity and belonging, whilst going through a difficult time. Others with mental health difficulties had felt ostracised, judged or blamed within their church congregation.

The researcher had also known people who had volunteered within the church to support people with mental health difficulties. Some found themselves managing a range of difficult situations such as disclosure of physical and sexual abuse and suicide attempts. In some contexts the volunteer was supported by senior leaders to manage the situation, in others they seem to have been left alone to handle situations of high risk or considerable emotional turmoil. As a consequence the researcher is interested in how different churches support people with mental health difficulties. In addition, she has an interest in why particular support structures are in place and how they become established.

The researcher is aware that being too close to the topic may impact her critical detachment. However, Strauss and Corbin (1998) postulate that this can be advantageous for the researcher to sensitise them to potentially important concepts.

## **2.7 PARTICIPANTS**

### ***2.7.1 Inclusion criteria***

To ensure participants had current experience and thoughts on this topic, participants inclusion in the research was based on the following criteria:

- Be a senior leader within a protestant Christian church- this was to ensure some consistency across Christian beliefs
- Lead a Church within south Wales



- Having been in church leadership for one year or more

### **2.7.2 Exclusion criteria**

Leaders of non-Christian religious groups were not included. Seventy-two percent of people in Wales categorise themselves as being Christian (ONS, 2001) so it remains the largest religious group in the country. It was expected that the 'lived' experience within Christian churches would vary hugely, despite shared theological belief systems. To extend the sample to other belief systems would risk the data being so heterogeneous that meaningful conclusions could prove difficult.

### **2.7.3 Recruitment**

Search terms such as 'Christian church south Wales' were entered into an internet search engine in order to access Church leader's contact details. A selection of denominations including Anglican, Baptist, Presbyterian, Non-denominational, Pentecostal, Evangelical, Jesus Army and Methodist were contacted. An information sheet (see Appendix 4), a demographic questionnaire (Appendix 5), a reply slip (Appendix 6) and a stamped-addressed envelope were sent to 36 church leaders. If the leaders were interested in taking part they were encouraged to respond by post, email or to telephone the doctoral training course and leave a message.

### **2.7.4 Return rate**

From 36 invitations sent, 1 was returned to sender, 2 replied to say no, 10 said yes and 23 did not respond. There were no clear differences between those who did and did not respond. Half of the church leaders were from non-denominational churches, it is possible this is not a representative sample but the author was not able to find any information on the number of churches representing each denomination in south Wales.

### **2.7.5 Description of participants (situating the sample)**

Nine white male church leaders and one white female leader took part in the first part of the research. All of them were married. See table 2.1 for a more detailed description of each participant. In order to protect participants' anonymity pseudonyms were given and age was stated according to an age band.

In line with theoretical sampling, towards the end of the data collection two further individuals were recruited to further expand upon emergent themes by being invited to comment on the findings to date (Glaser, 1978). One individual invited to comment was a Chaplaincy manager for a local health board who had previously had been the lead for mental health in a local health board. The researcher considered him to bridge the gap between the church and the NHS.

The other was a clergyman, who leads a training school for future church leaders. In the past he had advised on government policies regarding spirituality and mental health, as well as having an academic career. He was invited to comment as he was in a position to influence what was taught to future church leaders. He is referred to as the strategist from herein, due to the impact he has had on local and national strategy, especially in regards to what church leaders are taught.

Table 2.1: Participant's demographic information

Name	Denomination	Age band	Ethnic Origin	Number of adults in church	Number of children in church	Highest level of education	Number of years in church leadership	Number of other leaders on same level within the church
Owen	Anglican	41-45	White British	160	40	Degree	10	0
Tom	Apostolic	60-65	British	330	Unknown	Certificate in religious studies	35	0
Lewis	Conservative Evangelical	30-35	British	130	20	Degree	8	1
Ben	Non-denominational	56-60	British	400	150	Post-graduate	28	4
Clive	Non-denominational	41-45	British	150	Unknown	Post-graduate	15	1
Steven	Non-denominational	56-60	British	130	20	Degree	28	4
Rhys	Anglican	56-60	White British	145	25	Degree	16	0
Ed	Baptist	41-45	White British	200	50	Degree	19	1
Tim	Non-denominational	30-35	White welsh	40	15	Degree	3	1
Lisa	Non-denominational	36-40	White Asian British	70	25	NVQ	9	1

### **2.7.6 Ethical approval**

Prior to starting the study the researcher contacted the Cardiff and Vale Local Health Board Research and Design department who confirmed that National Health Service Ethical approval was not necessary, as no NHS patients were taking part in the research (see Appendix 7). Instead full ethical approval was sought from the Cardiff University School of Psychology Ethics committee, allowing an independent assessment of the presence of any contentious issues raised by the study. Full ethical approval was given (see Appendix 8 and 9).

### **2.7.7 Informed consent and confidentiality**

Verbal and written consent was sought in the first instance via responding to the information sheet which detailed the aims of the study, the procedure and what would be required of the participants, information about what would be done with the data and a statement about the right to withdraw. At the beginning of the interview the study was explained in detail, highlighting issues of confidentiality, consent and the audio taping of the interview. The consent form was then given to the participant allowing them to consider whether they felt they had received adequate information about the study in order to make an informed decision (see Appendix 10).

Confidentiality guidelines were adhered to (British Psychological Society, 2005). Before the interview began the participants were assured that confidentiality would be maintained. The participants were asked not to use any names. To ensure confidentiality any identifying details such as names, places or distinguishing life stories that were given were altered. To ensure anonymity and confidentiality each participant was also allocated a unique identity number during analysis and referred to by pseudonym thereafter. Following the research, participants were debriefed. The aims of the study were discussed and an opportunity to ask questions was provided. Permission to invite them to participate in the next stage of the study was sought.

## **2.8 PROCEDURE**

The procedure will be briefly described; its constituent parts will then be expanded upon below. The researcher sent church leaders postal information sheets and invites to take part in the study, along with a demographic questionnaire. After confirming their wish to take part by contacting the researcher by post, or via a telephone conversation, or email, a date for interview was set. On the day of the interview the aim of the study was explained, the opportunity to decline provided, and the consent form was signed. If not already completed, the demographic questionnaire was filled in. Following the analysis of the data the participants were sent a brief version of the results to comment on. At this point the results were also presented, in person, to the Chaplain and the Strategist for comments. Finally, the inter-rater reliability was conducted with randomly selected excerpts from transcripts.

### ***2.8.1 Demographic questionnaire***

A brief questionnaire was designed to provide information on participants that would set the context for their responses. Information about marital status, ethnic origin, highest level of education achieved, church denomination and number of years in church leadership was sought.

### ***2.8.2 Interview schedule development***

A semi-structured interview schedule was designed by the researcher with stem questions related to key research questions and additional prompts to facilitate further exploration of ideas. The key research questions were:

- 1) How do church leaders support members of their congregation with mental health difficulties?
- 2) What influences the way in which church leaders support members of their congregation with mental health difficulties?
- 3) Are leaders aware of how to access NHS resources to support congregants with mental health difficulties?

The stem questions in the original schedule, designed to assess the above research questions were as follows:

- 1) What do you believe enables an individual to maintain good mental health?
- 2) What do you think causes mental health difficulties?
- 3) In your opinion are religious people more or less likely to suffer from mental health problems than non-religious people?
- 4) I would like you to tell me about your experiences supporting members of your congregation with mental health difficulties. Perhaps one or two spring to mind? Maybe you could start by describing how their difficulties were brought to your attention.
  - How are mental health difficulties different to spiritual struggles?
  - How did you decide what support they needed?
- 5) Could you give me some examples of the kinds of situations in which you would suggest a member of your congregation sought help from mental health services?
  - What mental health services would/have you recommended?
- 6) Have you had any experiences of supporting someone in your congregation who is also receiving support from mental health services? What was that like?
- 7) Have you received any training that helps you understand and support people with mental health difficulties?
  - Is there any training or support that would enhance the work you do with members of your congregation with mental health difficulties?
- 8) What kind of support do you think mental health services could provide to assist the church?

9) Do you, your family or friends have any personal experience, of mental health difficulties?

- How has this impacted your beliefs about mental health difficulties?
- Did this impact on how you support congregants with mental health difficulties?

10) When taking part in today's interview did it make any difference knowing that I am a Christian?

- In what way?

The 10th question was taken from Cutland (2000) in order to ascertain how pertinent the researcher's faith was to those being interviewed, to inform reflexivity and further research.

The researcher gained feedback on the interview schedule from her two supervisors, in particular to check for assumptions within the questions asked. A pilot interview was also conducted with a church leader. He fed back that the questions asked seemed relevant and the tone and mode of questioning was appropriate. His data was then discarded.

Following each interview with a participant any pertinent lines of enquiry, or questions which needed clarification, were incorporated into later interviews. The following questions were added:

#### **After Interview 1**

- How do you differentiate between spiritual and psychological difficulties?
- Do you have any experience of managing risk? By this I mean people who are in danger of harming themselves or anyone else?
- The wording in question 3 was altered from religious/non religious to Christian/non Christian due to the confusion the initial wording caused.

#### **After Interview 2**

The demographic questions were added:

- How many people are in your congregation?
- Roughly what percentage of your working week is spent supporting people in your congregation with mental health difficulties?

#### **After Interview 3**

- I am interested in why you have this support structure- who set it up?
- Do you think the NHS can offer any support that you as a church cannot?

#### **After Interview 4**

- Do you have any examples of when the support you have offered has not worked?

#### **After Interview 5**

- How is your own emotional and psychological wellbeing looked after?
- The majority of church leaders I have interviewed have talked about not considering themselves an expert but they do not seek the help of experts in mental health very often. Do you have any thoughts about why that is?

The interview occurred in a setting convenient to the participant. The researcher began the interview by explaining the purpose of the research, confidentiality and how the data would be handled. The participants were asked again whether they wished to take part and were then asked to sign a consent form. If the demographic questionnaire had not been returned in the post it was completed before the interview began.

The interview *was* recorded on an MP3 player and took between 51 and 85 minutes to complete. After the interview the participants were debriefed.

## **2.9 DATA ANALYSIS**

### ***2.9.1 Transcribing interview data***

Interviews were transcribed verbatim by the interviewer, or in two instances, by a paid transcriber who came recommended to the researcher. In order to protect



participants' anonymity all names were changed. On the rare occasion when the researcher was concerned that a story told might identify the leader, some minor details were changed to prevent this from occurring. This was done in a manner which did not influence the results.

### **2.9.2 Analysis of interview data**

The researcher did not use computer software such as NVivo because of the wish to stay close to the data and for the data (not the software) to drive the means of analysis (Goulding, 1999). As the researcher was new to the process she wanted to use a manual approach (Weitzman, 1994). Microsoft Word was used to collate codes within separate documents and Bubbl.us (a web-based project mapping tool) was used to arrange codes into categories.

The researcher followed grounded theory procedures as described by Strauss and Corbin (1998). Therefore, an iterative process of data collection and analysis occurred. The iterative nature of grounded theory was attended to by the interviews being spaced with enough room to transcribe, code and analyse the data in between. Additional questions were added following each interview where new topics arose (see 2.8.2).

The transcripts were examined line by line and open coding was used to break the data down into distinct units of meaning, which may be words, phrases or sentences (Lyons & Coyle, 2007). The units were given descriptive labels (categories) which were grounded in data, not theory or formulation (see Appendix 11). Constant comparison was employed as new units of text were compared against previous categories using the Windows 7 function of moving between multiple Microsoft Word windows (representing multiple categories) (Strauss & Corbin, 1998). Constant comparison with new examples was also employed in an attempt to saturate the category and to maintain a close comparison between categories and the data.

Throughout the process, a research diary was kept as a record of the ongoing dialog with self (see Appendix 12). By recording ideas and questions the researcher

defined what was implicit and explicit about the data and detailed the core meanings of codes. Charmaz (2001) recommends that the researcher includes *in vivo* extracts in their memos to keep the participant's voice and meaning present. The memos also track reflections on the adequacy of the research questions (Willig, 2001).

Following the first four interviews an interim analysis was conducted, allowing reflection of the evolving themes. This enabled theoretical sampling to occur as individuals were recruited to further expand upon emergent themes (Glaser, 1978). Theoretical saturation was attempted, operationalised as the point where no further categories could be identified from data collection or analysis and the category had well-developed dimensions. However, it was recognised that this "functions as a goal rather than a reality because modification of categories or changes in perspective are always possible" (Willig, 2001, p.37).

Axial coding then occurred, which is the process that appreciates concepts in terms of their dynamic interrelations (Goulding, 1999). This interconnects main categories to sub categories which builds a conceptual model and determines whether sufficient data exists to support the interpretation. Corbin and Strauss (2008) describe the distinction between open and axial coding as 'artificial' but operationalised both in order to explain how 'data is broken apart' to identify concepts but put back together by relating the concepts to each other. The web tool Bubl.us was utilised to create spider diagrams depicting the interconnections between categories.

Selective coding was the final stage where the categories are connected to each other, in order to produce 'a discursive set of theoretical propositions'. In this process one category is chosen to be the 'core category' and all other categories are related to it. Corbin and Strauss (2008) suggest finding a single category as the central phenomenon (concept) as this becomes central to the explanatory framework.

## **2.10 EVALUATING THE QUALITY OF THE RESEARCH**

Several authors have debated criteria for judging the quality of qualitative research (e.g. Elliot *et al.* 1999, Henwood & Pidgeon, 1992). Within a critical realist

framework, triangulation, using multiple perspectives, can be used to assess the reliability of qualitative analysis. Triangulation aims to show that results can be broadly reproducible (Bunge, 1993) whilst not assuming that there is one reality that can be revealed through the utilisation of correct methodology (Madill *et al.*, 2000). Instead, there is a keen desire to find grounding for the results (Madill *et al.*, 2000). Charmaz (1990) suggests that the rigour of grounded theory rests on developing a range of relevant conceptual categories, saturating those categories and explaining the data.

Elliot *et al.*'s (1999) guidelines were followed to assess quality of the research. This included: owning one's perspective, situating the sample, grounding in examples, providing credibility checks, coherence, accomplishing general vs. specific research tasks and resonating with readers (see section 4.5 for further details on the extent to which each criterion may be said to have been fulfilled).

## **2.11 VALIDATION OF THE ANALYSIS**

### ***2.11.1 Theoretical sampling***

After the analysis, the researcher wished to present the results to people who bridged the gap between the church and the NHS but held a different perspective from the church leaders. A mental health chaplain seemed ideal due to being positioned as clergy within the NHS but not within a church environment. In addition, the categories which were constructed suggested that the lack of training church leaders received was a significant issue. Hence, the strategist, who trained future church leaders, was approached. Neither the chaplain nor the strategist's comments were included in the analysis, but do appear in the results section as commentary on the findings.

### ***2.11.2 Respondent validation***

After the analysis of the ten interviews was drafted, respondent validation was employed (Barbour, 2001). A brief version of the results were sent to the church

leaders to assess 'respondent validity', which is based on the notion that grounded theories should "work", 'fit', and be recognisable and of relevance to those studied" and that, "If participants agree with the researcher's account, then greater confidence can be attached to it" (Henwood & Pidgeon, 1996, p.84).

A brief version of the analysis was emailed to the church leaders and they were asked to respond on a 5 point likert scale in accordance with how much they agreed with the following statements (Response options ranged from 'Not at all' to 'Very much so'):

1. This analysis makes sense to me
2. I can recognise my experience in this analysis
3. I think the understanding provided by this analysis will be useful to me

These questions were based on those asked by Cutland (2000) who took questions 1 and 2 from Green *et al.* (1998) and asked question 3 due to Stiles' (1993) suggestion that 'usefulness to participants of interpretations' should be a standard of validity.

The participants were given three weeks to respond. Six church leaders returned feedback (see 3.3).

### **2.11.3 Inter-rater reliability**

It was intended that inter-rater reliability would be utilised, involving the nonparametric 'coefficient of concordance' as a measure of inter-judge agreement regarding categories and quotes (see Baker & Wang, 2004 for further example of this technique). However, the level of agreement was so high percentage agreement was reported instead.

The reliability check was completed by assigning each category a number and using an internet number generator to select 6 categories. Four to six quotes belonging to that category were then randomly selected, resulting in 30 quotes being picked (see

Appendix 13). Two Clinical Psychologists (one an atheist, the other a Hindu) and a Christian lay person were selected. The author chose these people as she hoped the research would be accessible to both psychologists and non-psychologists, those with religious beliefs and without. The individuals were each given the six selected categories (with brief definitions). They were asked to match the quotes to the category they best felt fitted. This was then compared to the allocation by the researcher (see 3.4).

## CHAPTER THREE: RESULTS

### 3.1 OVERVIEW OF CHAPTER

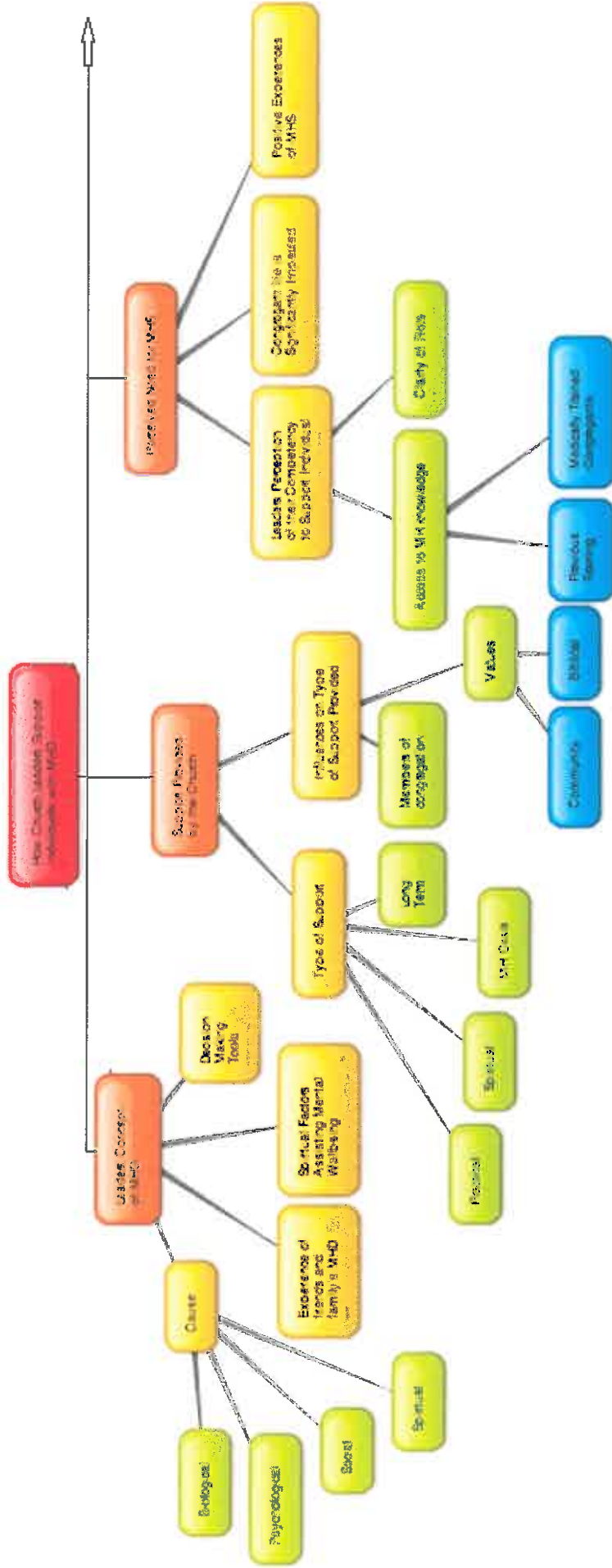
This chapter presents a grounded theory analysis of interviews with church leaders regarding their experiences of supporting congregants with mental health difficulties. The results presented in this chapter are socially and contextually bound responses from church leaders, therefore do not provide 'definitive' answers to the questions of the research<sup>3</sup>.

The author deliberately chose broad research questions as she was unsure what was going to emerge. The interview transcripts were analysed (see 2.9). Figure 3.1a and Figure 3.1b depict a summary of the analysis summarising the 4 core categories (in orange boxes), 14 categories (in yellow boxes), 17 sub-categories (in green boxes) and 4 sub-sub-categories (in blue boxes). Each category will then be discussed alongside illustrative quotes. Quotes from the interviews are preceded by the leader's pseudonym. Anyone mentioned within the excerpt was also given a pseudonym to protect anonymity. Excerpts from the two additional participants who validated the findings, the Chaplain and the strategist, are also included on occasion.

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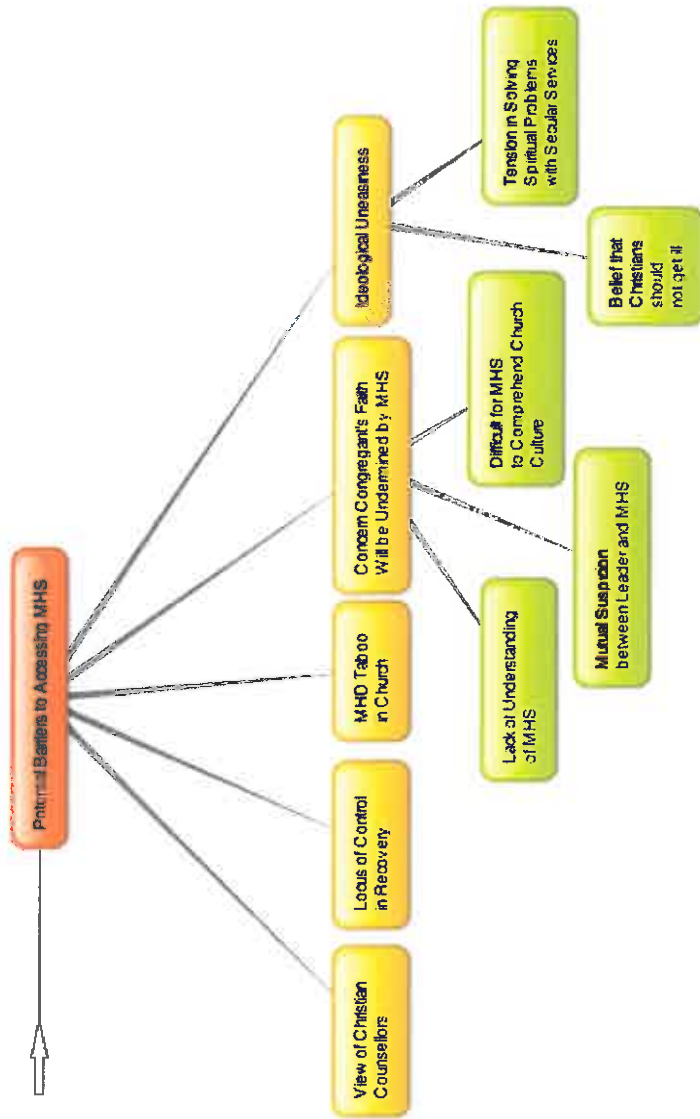
<sup>3</sup> The analysis was largely conducted on a descriptive level "the result is a systematic map of concepts and categories used by the respondents" (Willig, 2001, p.49).

Figure 3.1a Diagram showing a summary of the Grounded Theory Analysis



**MHD:** Mental health difficulties  
**MHS:** Mental health services

Figure 3.1b Diagram showing a summary of the Grounded Theory Analysis



**MHD:** Mental health difficulties  
**MHS:** Mental health services



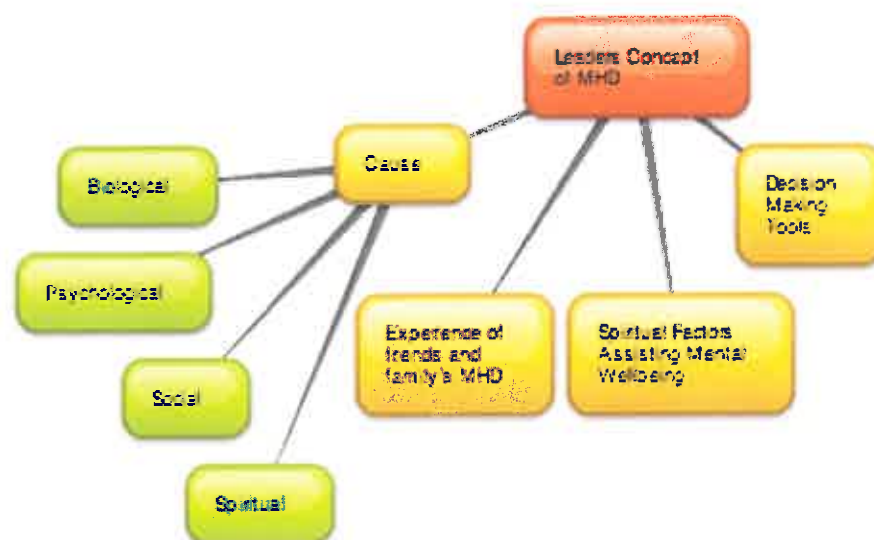
### 3.2 GROUNDED THEORY ANALYSIS: MAIN CATEGORY: How Leaders Support Individuals with Mental Health Difficulties

The main category, 'How Leaders Support Individuals with Mental Health Difficulties' encompasses all elements of the interviews with the church leaders. Throughout conversations with the leaders it seemed that there were key ways in which the leader decided how to support the individual, which became the core categories. The core categories were labelled 'Leader's Concept of Mental Health Difficulties', 'Perceived Need for Mental Health Services' and 'Support Provided Within the Church'. There is an additional category labelled 'Potential Barriers to Accessing Services' which is related to each of the categories and is also directly related to the core category.

#### 3.2.1 CORE CATEGORY ONE: LEADER'S CONCEPT OF MENTAL HEALTH DIFFICULTY

The core category 'Leader's Concept of Mental Health Difficulties' contained the subcategories 'Cause', 'Experience of Friends and Family's Mental Health Difficulties', 'Spiritual Factors Assisting Mental Wellbeing' and 'Decision-Making Tools.'

Figure 3.2: Diagrammatic representation of 'Leader's concept of Mental Health Difficulty'



### **3.2.1.1 CATEGORY: CAUSE OF MENTAL HEALTH DIFFICULTIES**

This category relates to the church leaders' cognitive representation of what causes a mental health difficulty. All of the church leaders discussed the causes of mental health difficulties and their ideas spanned social, biological, psychological and spiritual factors.

#### **3.2.1.1.1 Subcategory: Biological causes**

Several leaders acknowledged biological causes of mental health difficulties, some as a definitive cause, such as being '*chemically imbalanced*', or the mental health difficulty being inherited:

Steven: *"It can be inherited I think. I've come across situations where someone's mother, and indeed grandmother, has suffered mental health problems"*.

Others considered biological causes in a cumulative manner, alongside social or psychological factors. Lewis expressed the complexity of establishing causality of mental health difficulties:

*"It's not as simple as circumstantial; sometimes it is something going on in their brain so it is a medical thing as well ... But then sometimes it is circumstance that will lead to the medical problem; so sometimes it's like they have not got enough serotonin in the brain which may lead to depression."*

#### **3.2.1.1.2 Subcategory: Psychological causes**

Half of the leaders made reference to psychological causes of mental health difficulties. Some described a lack of ' *coping skills*' which were thought to vary between congregants. '*Poor decision-making*' was also thought to contribute, leading to emotional distress. Leaders had a sense that the individual's beliefs about the self and how others perceived them could also cause mental health difficulties:

Tom: *"I think people have got to have a right understanding of themselves, a good understanding of themselves, a healthy understanding of themselves"*.

Half of the leaders also mentioned guilt. As it is an emotion, it has been placed in the psychological causes category, although many leaders suggested that guilt might be a response to a spiritual transgression. Guilt could be caused by the individual feeling they were letting themselves, God, or congregants down. It was also thought to be caused by the individual feeling as if they are failing to meet the expectations of other congregants. Tim believed that Christians had a keener sense of right and wrong and that this led them to set higher expectations of themselves and their behaviour and know what *'the Lord'* expected of them:

*"She felt really guilty about some of the stuff she had done whilst she was depressed. So Christians, in a sense, their conscience is a lot sharper. If they are genuine Christians, then there is some sense of moral right or wrong. So on that level perhaps they are more likely to have some kind of anxiety. Especially if they are wilfully sinning or backsliding. I genuinely believe that the most unhappy people on the planet are backslidden Christians who have 'tasted and seen that the Lord is good' and then rejected it".*

#### **3.2.1.1.3 Subcategory: Social causes**

The majority of leaders felt that mental health difficulties could be caused by a lack of connectedness to others, especially if relationships with friends and family were not stable:

Owen: *"They are very isolated and that brings with it depression and anxiety".*

Whilst being isolated from others was thought to impact on mood, so was the inability to maintain personal boundaries. Leaders felt that individuals without social boundaries in personal relationships might expect too much from others:

Lewis: *"I think when people have poor boundaries their emotional health often seems to suffer".*

The majority of leaders thought that mental health difficulties could be caused by events occurring for an individual such as losing a job, difficult living situations or someone dying, and that such factors might lead to stress. They acknowledged that the emotional response to the stress could 'trigger' a mental health difficulty:

Rhys: *"I think most of the people that I come into contact with who've got ... major mental health problems, have probably had some sort of emotional upset or something like that in their lives. And often not dealt with it ... it feels like it eats into their system and at some point it explodes and comes out"*.

#### **3.2.1.1.4 Subcategory: Spiritual causes**

All the church leaders thought that mental health issues had some spiritual element to them. However, where some felt that the spiritual element was the main cause, others felt it was one of many causes. Hence, the issue of equifinality arose. One leader felt that mental health problems were entirely caused by spiritual issues:

Lisa: *"Well, they are one and the same thing [mental health and spiritual difficulties]. I wouldn't say there was any difference; it is just the labels we put on them. People in the world would not know it was a spiritual thing but ... it is spiritual."*

For three of the leaders, Lisa, Ben and Lewis, the devil was at work in mental health difficulties, operating as an evil being who was 'out to kill and destroy'. Lisa described how she thought the devil gets into the mind, and into the heart:

*"You see if he [the devil] can get the mind up, because that is where things go-into the mind, you think about it and then things go into the heart ... so the enemy suggests all these things and he plays around with peoples' thoughts and people's thought processes."*

Lisa and Ben also felt that a cause of mental health difficulties was the way in which people spoke. Some Christians believe if an individual speaks negatively bad things can happen, which stems from an interpretation of a bible verse<sup>4</sup>:

Ben: *"I believe that words have power, creative power and destructive power ... If someone says 'I hate you' or 'you will be a failure all your life'. If we allow those things to get in they can become part of us ... I believe the Bible teaches that ... I think words can be very affirming or destructive, so I think in mental health the way we speak is a very important thing"*.

Lisa and Ben both gave examples of 'people talking themselves into an illness'.

Lisa: *"If you are constantly saying 'I'm ill, I'm ill, I'm ill', that's exactly what you will be. It is amazing how the confession [what is said out loud] makes a difference in how you react, how your body reacts. You know we have seen it through different people when they confess things over their lives, negative things, that is exactly what happens"*.

Ben: *"I have known someone who talked themselves into a wheelchair because they said 'I am going to be ill. I am ill' and they went into the wheelchair. The doctors said 'really there is not much wrong with you at all'. They said 'no this is where I am going to be now' and they were in a wheel chair for 20 years. No matter what was prayed for them or taught to them they said 'yes, well this is how it is going to be'. It was sad ... I do believe there is an enemy of our faith who wants to destroy people"*.

Some of the other church leaders, including the Chaplain, had strong views against the devil being described as a causal explanation for mental health difficulties:

*"Those people ... have a very closed world view that overall God is responsible for everything that happens, when things go wrong it's not God's fault it's the devil's fault ... my outlook is, yes, God is in control but shit happens and it would do some church*

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<sup>4</sup> "The tongue has the power of life and death and those who love it will eat its fruit" Proverbs 18:21 (The Bible)

*leaders a bit more to say that every now and then. Things happen and why they happen and to whom they happen, we haven't got a clue."*

Other Church leaders spoke about more distal ways in which spiritual elements impacted an individuals' mental health such as feeling that they were letting God down, or not connecting with God often enough through reading the Bible or by praying.

Steven, who also described the hereditary nature of mental health difficulties, described how reappraising God in a negative light had maintained distress for a young man who had been diagnosed with Bipolar Disorder:

*Steven: "I think he was feeling that God was condemning him in some way because of the way he was feeling and all that. It was just a whole mish-mash, really, of issues and doubts and fears. He didn't lose his faith completely but, as I say, his relationship with God was poor. God had stopped becoming a loving Father and instead had become someone who was constantly condemning him".*

Two leaders were certain that the devil was to blame. However, half of the leaders offered biological, psychological or social explanations but admitted feeling uncertain as to what causes mental health difficulties. One claimed the cause of mental health difficulties 'does not fit a formula'. Another admitted, 'it is difficult to know where the line is' between when a presenting problem has a spiritual cause and when it has psychological one. Several leaders resisted a reductionistic approach to congregants' difficulties:

*Ed: "The honest answer is I don't know [what causes mental health difficulties]. I don't know if you can divide a person into emotional, spiritual and physical, it's not clear cut and neat like that. Erm so I'd, I think it's trying to see the whole person rather than subdividing them into bits probably helps. And kinda seeing that everything is spiritual."*

### **3.2.1.2 CATEGORY: EXPERIENCE OF FRIENDS AND FAMILY'S MENTAL HEALTH DIFFICULTIES**

The majority of leaders had experienced mental health difficulties in friends and family members. This impacted their concept regarding what mental health difficulties are in a number of ways.

Clive felt that a member of his family having committed suicide had made him aware of what should not be said to people in that situation:

*"We're very aware of issues of suicide ... more aware that 'pull yourself together' doesn't work."*

Tim's wife had been sectioned due to low mood when she was younger and this had a profound effect on his beliefs about how people recover from mental health difficulties:

*"She was literally delivered or healed from it. She would say it was only the grace of God, through the power of the gospel, that brought her out of a very dark place where ... she couldn't do life anymore."*

A close family member of Rhys' had been diagnosed with depression, which increased his awareness of the difficulty:

*"I don't think until you've come across it that closely that you realise how much there is of it around ... a huge percentage of the population are dealing with things like this ... I think before I was quite open about it, and quite accepting, but more so now".*

The national leader of Lewis' denomination had been diagnosed with depression in the past and this had impacted on the training of Church leaders at a national level:

Lewis: *"He [national leader] put on this conference about depression because rather than sweeping it under the carpet and saying "God doesn't do depression and*

*people shouldn't get depressed" it's like, "no actually people are struggling with this and we need to give them coping mechanisms."*

### **3.2.1.3 CATEGORY: SPIRITUAL FACTORS ASSISTING MENTAL WELLBEING**

Whilst talking about the causes of mental health difficulties, the leaders also described how having faith protects against mental health difficulties, including the benefits of having a relationship with God. Several leaders described the comfort that comes from knowing that God understands and accepts you:

Ed: *"so it is helping them to connect their family tensions and pressures with a God who understands those things and holds those things in tension".*

Another benefit of a relationship with God was the constancy He provided:

Rhys: *"You know, for me, I've got all my family, I've got all my support network, but actually beyond all that I've got Jesus Christ ... I know that he can transcend everything that happens to me ... that he's there, whatever my family do, even if ... I lose that support from them ... He is constant. And for me I think that may be one of the things that keeps people well."*

Chaplain: *"I think my theological insight there, based on scripture is God says "I will never leave, nor forsake you ... who can separate us from the love of God? Can death or life, can cancer or psychosis, can depression? No, in all these things we are more than conquerors. So you know the Bible, a theological framework will help us there, that even death is not something that separates people from God. Perhaps sometimes people who are suffering need to hear that".*

Faith, defined in the Bible and by Ed as *"the assurance of things hoped for"*<sup>5</sup> was thought to result in a preponderance of positive beliefs that could aid mental wellbeing, such as the belief the individual can overcome difficulties and of having a

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<sup>5</sup> "Now faith is being sure of what we hope for and certain of what we do not see" Hebrews 11:1



purpose in life. Moreover, several leaders spoke about the benefit of the hope that they felt belief in God provided:

*Clive: "Hope that things aren't necessarily going to stay the same, that there's a way forward and that they can see that things can change and get different because we're a church community, a Christian community, that hope we find in God's Word and in God's promises to us."*

Two leaders commented on hope being something belonging to Christians, that others could not have and that mental health practitioners were unable to offer.

*Clive: "What I do I think which would be different to say a clinical practitioner, if you like, is I would go there to give hope. Hope for the future. Things don't have to stay the same. To tell them that God loves them, obviously, and I think that makes a big difference... There is a hope I can give people in Jesus Christ"*

#### **3.2.1.4 CATEGORY: DECISION-MAKING TOOLS**

The majority of the leaders' ideas about of the causes of mental health difficulties related to more than one type of explanation (e.g. spiritual AND social). When this was the case and leaders were faced with a congregant in emotional distress, they describe engaging in a decision-making process. Lewis describes the three elements he tries to untangle in the process:

*Lewis: "What is the combination of God's involvement, the world and the Devil? So I believe in the kingdom of God ... but we live in a broken world and I also believe in a devil who is there to devour and destroy. But what do we ascribe to the devil and what is just life? ... I think that moves into mental health as well and other difficult situations."*

Several tools were employed by the leaders to decide whether a congregant's distress was due to a spiritual or mental health difficulty. One tool was observation of the behaviour the congregant is displaying. Several behaviours, such as sexually

inappropriate acts (e.g. exposing genitalia), severe self harm, or acting in a uncontrollable manner whilst in a church meeting (called “manifesting”) were more likely to be attributed by some of the leaders as having a spiritual cause. This is because of the interpreted lack of self-control indicating being controlled by something else (a demon). The latter, although considered unusual by leaders, would indicate the need for “*deliverance*”<sup>6</sup>:

*Lisa: “There was this ... lovely lady but she has had problems all her life. And they started praying for her and [she] what we would call manifested ... it is like a spirit that gets inside you and it is a very ugly spirit. And it sort of freaks out the moment you are prayed for because it doesn’t want to come out. Well, this woman wanted to be free of all that stuff ... we had big round tables and she did a back bend over ... over the table. Now humanly is not possible right? So you knew what was going on straight away ... We said ‘do you want to be free of this’? and she was like ‘YES’.*”

Another tool used alongside observation of behaviour was *discernment*, a spiritual gift, given by God, which enabled the leader to detect if the problem is spiritual:

*Ben: “One of the gifts of the Holy Spirit is the discerning of spirits- what is at work here? and so I think you are able to, as you are talking with someone, and listening to someone, the Holy Spirit himself will begin to guide you and speak to you which sounds a little bit strange, I know, but that is what Christians believe- God speaks to us”.*

Three leaders used knowledge gained from *previous similar experiences* to decide, the more similar decisions they faced the easier it became:

*Ben: “Most of what I have learnt has been as I have faced situations”.*

However, Lewis described how cumulative experience had made him more confused about making the decision:

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<sup>6</sup> Deliverance from demonic power played a prominent role in Jesus’ and his disciples ministry (Mark 6:13, The Bible). A person was prayed for and the demon/s left them (Benedetto, 2008, p.295).

*“Where it is easy to start black and white and say “this is this” and “this is that”, I think the more I have gone on I have realised this is really complicated and I don’t always 100% know. So I think it’s really complicated ... some mental health difficulties are blamed as being spiritual issues which I don’t think they necessarily are, sometimes they are just mental health difficulties!”*

Tom highlighted the decision-making dilemma well. He described being called to the house to see a person in distress whom he had not met before. Some Christians arriving before him had decided that the difficulty had a spiritual cause due to the behaviour they had observed (disinhibited sexual behaviour):

*Tom: “This poor lady was in such a desperate ... state and was saying all sorts of sexual vulgarities to her husband and exposing the lower part of her body. In the other room there was another group of people ... from another church who had been called to pray and you know these people ... were praying ... and casting out the demonic spirits ... this lady was screaming, probably, you know the noise from the other room wasn’t helping either. I realised she needed a doctor and whatever spiritual problems she may have had, she was a sick woman, she needed to be treated for her sickness ... I said you have got to send out for a doctor ... she was sectioned that night”.*

Tom made the decision based on ‘discernment’ and his ‘common sense’, which helped him to consider the impact of the context the woman was in and to decide on a medical cause.

The Chaplain felt that the best way to decide was using both discernment and knowledge:

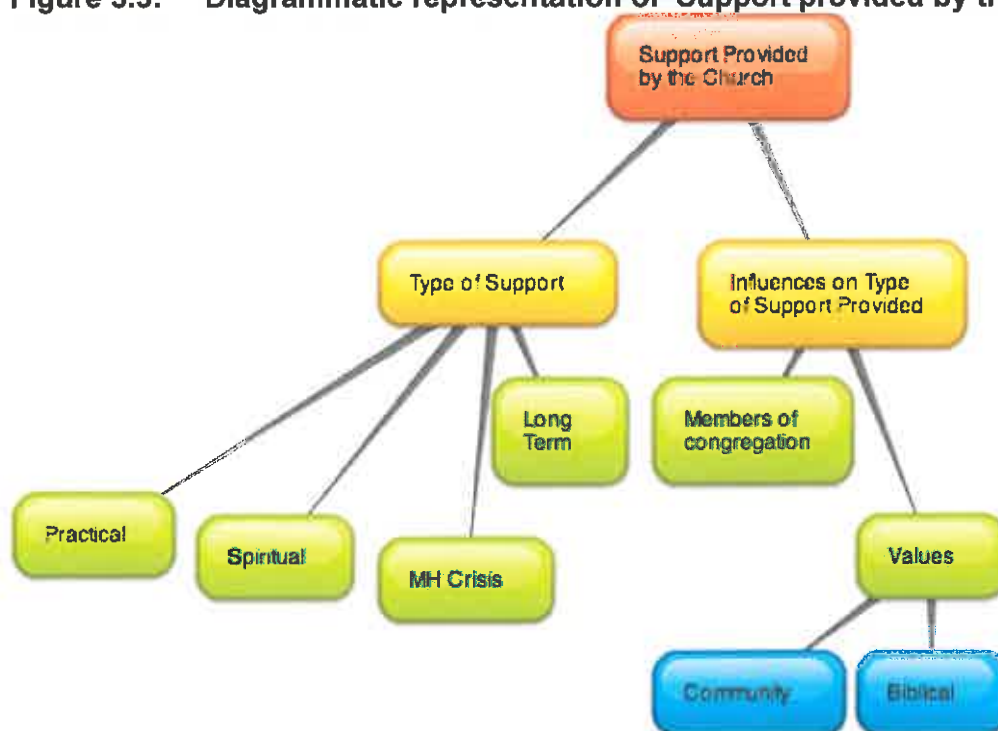
*“If we could send them [the leaders] on a two-week course on what is mental health they would probably have a different insight and have that discernment which is not just spirit-given, but is also knowledge-based and that is where the ignorance is, because their knowledge base is not able to apprehend that there are explanations*

out there which can assist and I think which can go together with a spiritual concept and with a medical, psychological background as well”.

### 3.2.2 CORE CATEGORY: SUPPORT PROVIDED BY THE CHURCH

One of the research aims was to explore what type support church leaders provided and what influenced the support structure they had implemented within their church.

**Figure 3.3:** Diagrammatic representation of ‘Support provided by the church’



#### 3.2.2.1 CATEGORY: TYPE OF SUPPORT

The church leaders were asked to talk about congregants they had supported in the past. In answer to this question and throughout the interview the church leaders described four different types of support given, which will now be expanded upon.

##### 3.2.2.1.1 Subcategory: Practical support

The leaders described being able to meet the basic needs of the congregants, such as shelter. Ben supported a severely depressed congregant who had just left his wife:

*“He left the marital home [and] he was going to sleep in the car. We thought ‘if you do that then I don’t think you will be here in the morning’ ... so I called up [a] couple and said, “listen, you know what is going on, are you able to help me?” They said “certainly, send him around” ... That is what church is about, not just a Sunday meeting. We practically care for each other.”*

Clive also demonstrated the prioritising of basic needs, providing food as well as listening:

*“If somebody sits in my office and they tell me all their problems I have to say “Do you have any food in your house?” and they’ll go, “No,” and I’ll say “Secretary, can you write me a cheque please. I’ll give this person some money, go get some food.’ It’s that sort of practical side of things as well. Jesus said this “Give to those who ask of you”.*

In the church context, it was not only the individual with a mental health difficulty who received support, their relations did too. Often the entire family was in the same church, so care could be provided to the whole unit, potentially preventing situations from worsening. Steven described a female congregant with severe depression:

*Steven: “I’ve been able to support this person’s husband because he’s obviously found it really, really difficult ... with trying to support their children ... the children’s workers-they’ve been made aware of the situation, so we can sort of keep an eye on the children as well, as a Church”.*

Other leaders were helping to keep relationships intact, for example, supporting the husband of an individual who had tried to kill them self. Sometimes leaders felt they were there at a crucial point, perhaps helping keep a family together:

*Ed: “That’s the other side of mental health care for us is supporting those who live with those who are suffering mental illness. For them it can mean the difference between the marriage lasting or not lasting, which involves children inevitably. So in*

*that particular case when this lady was particularly down, I remember talking to the husband in my garden who came round to say 'I can't take any more, I'm going to have to leave' ... He didn't, fortunately".*

Half of the leaders spoke about how they intentionally set up friendships with people with mental health difficulties as a way of providing practical support to them. Sometimes the leader encourages a congregant within the church to be the friend:

*Clive: "Buddying is very important so if you have somebody who ... wants our help—and a lot of people come into our community because of their situation ... it's giving them a friend and saying to somebody, "Look, I want you to just befriend them, look after them, talk to them."*

Sometimes, the leader himself or herself becomes the buddy. Steven, speaking about another leader in his church said:

*"She's an occupational therapist, and again, she's had experience dealing with people with mental health issues. She has befriended a young lady who's been coming to the church who has schizophrenia and has been a great support for her ... if you like, looks out for her on a Sunday and keeps in touch with her during the week. So that's been great for this individual actually".*

Lisa describes how accountable relationships are set up as part of the church culture to act as a form of encouragement and a way of reducing the impact of problems:

*"We always encourage accountability in our church... you know in school they call them bench buddies and they sit with them on the benches at break time to encourage them. You know, that's what it is really you know, you have those people alongside you to encourage you. You share your problems with them, a problem shared is a problem halved."*

### **3.2.2.1.2 Subcategory: Spiritual support**

The majority of support that leaders provided was given because of its perceived spiritual benefits. Some leaders spoke about encouraging individuals to seek prayer, individually or communally:

Tim: *"I would definitely encourage them to pray for healing and pray for total deliverance."*

Some churches had specific prayer-based teams who prayed with people regarding difficulties they were facing, or in other churches, prayed for deliverance from demonic influence.

All of the leaders offered individual pastoral support, based around talking. Four leaders referred to it as 'counselling'. Some leaders spoke of individuals who were receiving counselling in church and also from external counsellors. Owen described offering this counselling to a congregant who was actively psychotic at the time:

*"I just thought it's the least I can offer to spend time, and just talk and hopefully be somebody whom he can confide in."*

Ben had been supporting someone who was depressed after the demise of her business and said he would:

*"Listen to her ... get it all out and then just begin to construct within her a proper understanding of who God is."*

It is in this context that leaders described building relationships and allowing issues to emerge.

Another element of spiritual support offered for people with mental health difficulties was teaching given either to the individual or to the congregation. A number of topics were mentioned, spanning what it means to be a Christian, belief that God is near

and active, speaking positively, and trusting God. Ed described aiming to remedy misunderstandings about illness and healing when teaching:

*"I think particularly in some Christian circles you can be made to feel that your solution is always a prayer away and it is instant, but that isn't necessarily everyone's reality. So we do try to be real in the teaching and prayers, those sorts of things. So we are not leading people towards disappointment [when the solution does not come quickly], but to God who is alongside them in difficulty I suppose."*

The Bible contains verses which are believed to describe an 'individual's new identity in Christ'<sup>7</sup>, for example, having access to a sense of peace. Tim felt that this teaching was integral for individuals with mental health difficulties, especially in the context of his geographical area:

Tim: *"With a Christian who has got depression, or any other mental health issue...you can take them to scripture, you can talk to them about what Christ has done for them, not in a kind of 'this could be for you' but 'this has happened for you therefore'..Walk out your identity and what is yours by right in Jesus.' So you know in a council estate where identity is a big issue we try and nurture our people and pastor them in a way where they know who they are in Christ, that is part of it"*

#### **3.2.2.1.3 Subcategory: Mental health crisis support**

The leaders had experienced supporting congregants at the point of crisis, when something had to be done in order to keep the congregant safe. Steven and Tom both spoke about supporting someone during the sectioning process:

Steven: *"We've got another chap in the church who ... suffers severe schizophrenia but it's managed through his drug programme ... I think he stopped taking his medication and we had a phone call from his small-group leader saying that ... they found him in the porch of the house ... and he was very poorly indeed. So we*

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<sup>7</sup> "Therefore, if anyone is in Christ he is a new creation; the old has gone the new has come!" 2 Corinthians 5:17 (The Bible)



*managed to get to him and immediately called the emergency support number for his social worker. We took him down to the hospital ... and the three of us sat with him until he saw the psychiatrist and they admitted him there and then."*

Half of the leaders had supported an individual by visiting them whilst they were in a psychiatric hospital ward:

Ed: *"I have visited when people are in a bad way in the hospital. There is a lady there at the moment we have contact with who is in quite a bad way. It is very difficult as they are so drugged up they don't know who you are or why you are there. It's quite sad really".*

Some leaders spoke about being the only person invited to see the congregant other than friends and family, highlighting being the individual of choice for some people facing difficult situations.

All of the leaders had experience of congregants who threatened, or attempted, suicide. Some, like Lewis, had received text messages or telephone calls from congregants saying they were going to kill themselves. Four leaders found themselves actively preventing someone from killing themselves. Lisa prevented two people on separate occasions from jumping off local buildings. Tom, Tim and Ed had searched for people who had disappeared, presumed to be about to attempt suicide. Tim had a particularly traumatic experience, which also sought to confirm his belief in the cause of mental health difficulties:

Tim: *"There was a guy in my area who committed adultery and I found him in a field with a shotgun writing a suicide note to his kids ... the police were with me and they managed to take the gun off him, he is a friend of mine but it was just he couldn't stand what he had done ... That was guilt that put him there more than anything else ... It was a bizarre thing, the most insane episode of my life probably and I still see him every day and we never talk about it ... He ended up in the mental health hospital for a while after that."*

Tim highlights the difficulty for church leaders when crisis occurs and relationships need to continue afterwards and hints at the personal impact such situations could have on the leader. Ed and Tim described how they had learnt to support people in crisis 'on the job':

Ed: *"I have plenty of times where people say they are going to kill themselves and it would be my fault if they did ((laughs)). I think the first time you panic and rush round but you quickly learn that it is emotional blackmail and if you deal with it in a calm way then you help them learn that is not the best way to get help and attention ... But most people, when they have been at their most vulnerable or aggressive, they have been in hospital"*.

Tim: *"First time that happened was on New Year's Day; a boy came down and said 'my Mum has just overdosed can you come and help?' That was a weird one ... we knew the Mother through the son and she just sat there, surrounded by tablet bottles waiting for the ambulance to arrive and I didn't really know how to handle it then, it was really bizarre ... so that one I just rode it out"*.

#### **3.2.2.1.4 Subcategory: Long term support**

Half of the church leaders spoke about providing long term support for some of the congregants they had worked with. Lewis compared this element of church-based support with that provided by the government:

Lewis: *"The government can put things in place but I don't think they can provide long term support to people [with mental health difficulties] like the church can ... I think the massive part that the church has to play in society is rehabilitation and, erm, walking with people through life and seeing them change"*.

Rhys was leading a church-based class when he met one man, who then over time became a friend, and then developed a mental health difficulty:

Rhys: *“He went through a really rough time when his marriage started falling apart. And he started self-harming ... I just got a call one day from the mental health unit down in the hospital again. And they said, “He’s put you down as next of kin... he’s desperate to come and talk to you”. He was in there for about a month ... I just went down there regularly to see him. And it’s basically, you know, been like that ever since ... And he became part of my family, really, because my kids loved him. As he’s become more stable he’s ... stopped harming himself, he’s got his job back ... things seem to have sort of settled down in his life”.*

Rhys’ commitment to the congregant led to him becoming accepted within Rhys’ family which may have aided recovery. This highlights the unique nature of the pastoral role, where the cared for individual moves from congregant to family friend. This movement in position does not occur in the therapeutic relationship between psychologist and client.

However, the Chaplain described the cost that long-term support of individuals with mental health difficulties could involve for the leader:

Chaplain: *“With mental illness it is something that goes on, and on, and on, and you really have got to have stamina to stay with it and not everybody who is in a position of leadership in the church has got that.”*

Nonetheless, some church-based support lasts a lifetime:

Ed: *“So we met one lady Lucy who came who is a schizophrenic ... heard voices and all those things and gradually she got befriended by people in the church and was made to feel welcome and that was the beginning of a relationship with Lucy that lasted for many years until she died of natural circumstances.”*

When Lucy died her family could not afford a funeral, so her long-term friends within the church collected money and paid the costs. When a congregant with mental health difficulties is well known by the leader, or other congregants support, can include detecting the first signs of relapse, Steven said:

*“So the day we heard he'd had another bereavement [which had previously resulted in a relapse] I went straight round to see him and encouraged him and tried to give him support and particularly encouraged him not to stop taking his medication because we didn't want another relapse.”*

### **3.2.2.2 CATEGORY: INFLUENCES ON THE TYPE OF SUPPORT PROVIDED**

One of the research aims was to explore why church leaders offer the support they did. The responses could be divided into two influences on the support structure, the first being the members of the congregation and the second being the values held by the leader.

#### **3.2.2.2.1 Subcategory: Members of the congregation**

Lewis, Lisa and Clive described how the support structure within their churches had been influenced by members of the congregation. Individuals had come forward with new ideas for how to care for people who had experienced events which could contribute to mental health difficulties:

*Clive: “There's a pregnancy crisis centre that runs out of here, post-abortion counselling ... Somebody had a vision, thought we should do something and I said yeah, go and do it”.*

The service had such a good reputation that people from the local authority made referrals to the crisis centre, *“over time we just won them [local GP's] over and they're just so resource stretched ... to send somebody to us for a number of weeks can be a help to the doctor” (Clive).*

The presence of people with mental health difficulties in the congregation also impacted on the development of support structures. Tim quoted the results of a prescription survey that placed his church within the top ten towns where the most antidepressants are prescribed in the UK:

Tim: *“There is a chance I am in one of the most depressed places in the UK ... I think at one point when the church was really small we had a ridiculous percentage of the church on anti-depressants. It was something ridiculous like 30% of the adults or 50%.”*

Consequently, the geographical location of Tim’s church meant he had a large number of people with a diagnosis of depression in his congregation. This afforded him experience of supporting congregants with mental health difficulties and led him to consider how best to support them.

#### **3.2.2.2.2 Subcategory: Values**

Another factor which influenced the manner in which church leaders supported individuals was the values the leader held. Two types of values were cited: community values and biblical values.

##### *3.2.2.2.2.1 Sub-Sub Category: Community values*

Creating a sense of community was highly valued by six of the church leaders. This value led them to aim to create a group where a person could belong and be accepted for who they are:

Lewis: *“Anybody is welcome to be part of the community. I think that is the purpose of the church, that anybody can be a part of it and where they don’t find a place in society hopefully they find a place in church”.*

Clive: *“People need family and most communities now are much more fractured, broken up than they used to be. People don’t live around their parents anymore, we’re much more transient. People move away and we don’t have family support or community support and it’s cultivating that within the local church that I think is probably the greatest help and need”.*

A lot of leaders spoke about the value of acceptance, whereby leaders felt that people with mental health difficulties may struggle to find places where they feel

valued. Owen and others felt *“the church is a positive contributing factor in helping people with their mental health”* because the congregation fosters a sense of acceptance.

Clive felt that an environment where people are accepted could be an antidote to the hopelessness that he felt sometimes led to suicide:

*“Young adults, in the area, a number of them have committed suicide. For me it’s when you lose hope and you lose meaning and you lose purpose, what is the point? If you give somebody hope and you give them an environment where they’re cared for and they’re valued and they know that value, then that just makes a huge difference”.*

For some leaders acceptance of people within the church also meant encouraging them that *‘it’s alright to admit you are struggling’*. Leaders described aiming to create a space where people could be honest in times of emotional distress:

Ed: *“I think for people who are going through emotional difficulties, relationship breakdowns, trouble. It’s good for them to know that, erm, they can exist in brokenness without feeling the need to be perfect. That there is time and space for that as well and faith allows that too”.*

#### *3.2.2.2.2 Sub-sub-category: Biblical values*

Several leaders related the way they provide support to their understanding of what the Bible says they should do. They thought the Bible told them what type of people they should support, *‘the broken, the lost and the vulnerable’*, and how they should respond to them, *‘the Bible says you should weep with those who weep and mourn with those who mourn’ (Tim)<sup>8</sup>*.

Clive described the manner in which awareness of how God, through the Bible, impacts on the way in which his Church provides support:

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<sup>8</sup> “Rejoice with those who rejoice, and weep with those who weep”. Romans 12:13

*“You have the Bible, which is the instruction book, and a load of bricks, which are the people. Then you look to the architect [God], find out what the plan is and you try and put it together and lead it in that way. For us the biggest thing about our church is the first letter of John [in the Bible] ... it’s just laced with all this stuff about loving one another. And so our structures are changing but they’re endeavouring to reflect what we see in the scriptures”.*

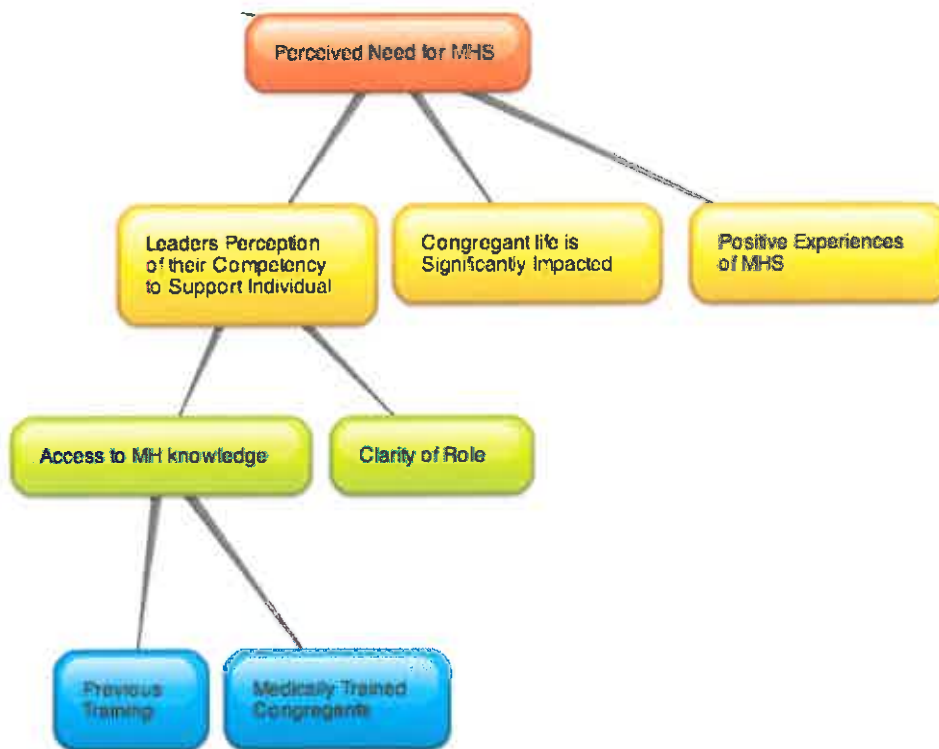
Several leaders referred to the Biblical theme of love as a strong influence in the way they went about supporting people with mental health difficulties.

Steven: *“I think this message we keep banging on about of grace and love. If you can show love and be gracious towards people with mental health issues that goes a long, long way to giving them the support they need”.*

### **3.2.3 CORE CATEGORY: PERCEIVED NEED FOR MENTAL HEALTH SERVICES**

During the analysis it became apparent that a continuum of how much Church leaders perceive a need for mental health services could be constructed. This perceived need could, in turn, impact whether or not they recommend mental health services to congregants.

**Figure 3.4: Diagrammatic representation of ‘Perceived Need for Mental Health Services.’**



### **3.2.3.1 CATEGORY: LEADERS’ PERCEPTION OF THEIR COMPETENCY TO SUPPORT INDIVIDUALS WITH MENTAL HEALTH DIFFICULTIES**

Leaders varied in how competent they felt to support individuals with mental health difficulties according to whether they had access to mental health knowledge and how clear they were regarding their role as a church leader. This in turn impacted on their perceived need for mental health services.

#### **3.2.3.1.1 Sub-Category: Access to mental health knowledge**

The knowledge the leaders held regarding mental health difficulties seemed to impact their judgement of their own competence to support individuals. Mental health knowledge was gained through training, accumulation of personal experiences and the impact of members of the congregation with mental health knowledge.



### 3.2.3.1.1.1 Sub-sub category: Previous training

The majority of leader's felt that they had little competency in the area of mental health difficulties and many cited the fact that they had not had any training. The words *'inadequate'*, *'ill equipped'* and *'under-trained'* were frequently used by the leaders. Owen had, like many leaders, been taught about bereavement. He had gone on to develop this as a special interest so had more knowledge about the subject than most leaders. Nonetheless, he still did not feel competent in supporting individuals with other mental health difficulties:

Owen: *"I feel very unqualified to deal with mental health or to be able to detect issues. There are specific things I can remember that emphasis was placed on [in my theological training], bereavement was one, erm, it doesn't stick in my mind if we had training in specific mental health issues. I don't think there was"*.

Tom had received theological training but it had not helped him to feel competent:

*"I don't think they [theological colleges] are helping people specifically to face the world and modern society and I wish we could be better equipped than what we are"*.

Ed was very aware that college had trained him to be a competent theologian, but not a competent mental health professional:

*"I'm not qualified to make the assessments ...You feel very inadequate; you are trained in theology, not mental health"*.

Tim described how *"church pastors, especially in places where I am, most of them have not got a clue on how to handle stuff like this"*.

Unsurprisingly, not feeling competent and feeling undertrained had an emotional impact on three of the leaders:

Rhys: *"There are times when ... I've felt snowed under. Because I need to help this person onto the next step of their healing process, but I don't know how to do it. And*

*there are times when I've got quite ... not depressed, but concerned that I couldn't get them onto a next step. I've gone as far as I can. But they do need that professional help and I don't know where to get it".*

The area that six of the leaders expressed the most difficulty with was detecting the presence of mental health difficulties. The leaders seemed surprised at how long difficulties could remain 'hidden' for:

*Owen: "He is obviously someone who had quite acute mental health issues, but if you saw him in church you would never know that, and if you saw him on the street you would never know that ... mental health is one of those things where often people suffer in secret and I don't feel qualified enough to pick up on these things."*

*Tom: "But goodness, imagine the state of mind that she is in [she wants to kill herself] and you know here is a lady that you wouldn't see in a crowd and pick out as the woman with mental health problems".*

The strategist commented on how his training scheme was attempting to combat this issue:

*"In the third year of the course here we take them through the pastoral studies course by a trained therapist who is a clergyman and they would have ten sessions. They would have a minimal awareness of what the nature of counselling is and above all what the pitfalls are ... how to listen, what signs of mental illness there are and a lot of the emphasis naturally would be to get them to know when to refer to professionals".*

The leaders who felt as though they were not competent to work with individuals with mental health difficulties were more likely to perceive a need for mental health services.

*Lewis: "There would be a number of different situations and I would always encourage them [NHS] to be involved. They have a level of expertise that I don't ...*

*so we are 100% supportive of what the NHS do, or what professionals do, and we would encourage that ... and we don't try and take that role."*

#### *3.2.3.1.1.2 Sub-sub category: Medically trained congregants within the church*

Ed, Lewis and Steven found the medically trained people in their church a useful resource in deciding whether outside services were needed. Ben reported the same:

*"It helps that we have a lot of medical people in the Church. A lot of doctors, nurses erm, not so many psychologists and psychiatrists- some. But mostly medical people, one of our leaders is actually a GP... we will draw on the wisdom of the medical people that we have and ask 'what is the best thing for this person?'"*

Lisa used three counsellors, who worked in secular services but attended her church, for advice:

*"... which is great because they are able to come from the professional side and give the worldly point of view as well as the spiritual".*

In contrast, Rhys was very aware of the lack of people to advise him within his church congregation:

*"I would ask the advice of them. "Where do I go with this?" But I hate to say it, I think a lot of the time ... there's nobody there to ask."*

He tried to access information by ringing his diocesan officer (a church leader higher up the leadership structure of his denomination) to ask for advice when looking for a professional Christian counsellor:

*"But they've often said people I already know, through people like Cruse ... or something like that ... [I am left with feelings of] absolute frustration that the Church here doesn't seem to have got those networks in place."*

### **3.2.3.1.2 Subcategory: Clarity of role**

The clarity of the leader's role refers to how much the leader is able to demarcate what their role is in supporting those with mental health difficulties, what other professionals' roles are and if they are aware of the boundary between the two.

Many leaders described what their role was:

Rhys: *"With Andy [a congregant], he was having regular visits back to the Mental Health Unit to talk to one of them ... I was very aware that I didn't want to encroach into that area when he was being treated by a professional ... So basically I just carried on doing what I always do, and trying to be that friend, that listener, that I would with anybody else, even if they weren't being supported by a professional ... I think I probably mentally step back a little bit. Because I don't want to encroach into that area that's not within my experience".*

Lewis described his role as *"a supportive prayer-based thing"*. Ed, reflecting on his lack of qualification, defined himself as *"just a good listener"*. Ben described his relationship with congregants as *"not like a patient-doctor relationship, it's a relationship of a friend"*. Clive felt that his role was to *"empower people to make their own decisions"* using advice from the Bible.

The majority of leaders also described limitations to their role:

Owen: *"I'm not a trained counsellor; I am a jack of all trades in lots of ways, so I recognise there are limitations in how I can help"*.

Ben: *"I have taken it on myself just to read and talk to medical professionals like psychiatrists, psychologists, surgeons, nurses and just glean from them as much as I can but that has made me realise even more that I am not a medical professional, so I think there is definitely a benefit in just being aware of these things because we can't replace, we are not here to replace, psychologists and psychiatrists"*.

Thus, leaders often had a sense of when they reached the limits of their competencies. For example, Owen recalled when he had supported someone with psychosis and suicidal plans:

Owen: *"I was very much aware that that was outside of my parameters. I'm not trained as a mental health counsellor ... I suppose it is when I start to feel I am out of my depth and the alarm bells ring"*.

Such experiences seem to highlight the boundaries between church and mental health services for some leaders:

Ed: *"The services we provide as a church, we have to recognise that they are limited. I often say to people there is a line we cross from a supportive service into professional care. We have to know where that line is so, so we can't be the NHS ... So I think it is really important to know where our limits are. I think there are [people with] far more expertise and professionalism and a much bigger support network than we can ever have. So we are just not geared up for it, I think if we tried to we would be in trouble very quickly, so I think it is very important to know where our limits are"*.

Tom: *"I know my boundaries ... and refer to those who are professionally trained"*.

Previous experiences enabled some leaders to have clarity regarding their role:

Rhys: *"My other challenge is in knowing my limitations. I've got to just decide, "Okay, I've done what I can do ... They need more than a good listener ... They actually need somebody who's visibly going to be able to help them deal with what's going on their head and in their background ... I've been in the ministry just over sixteen years now, I think experience now [helps me decide when I have reached my limitations] ... at one time, when I was younger, I think I would have pursued it further"*.

### **3.2.3.2 CATEGORY: CONGREGANTS' LIFE IS SIGNIFICANTLY IMPACTED**

When it is clear to the Church leaders that the congregants' mood or behaviour is significantly impacting on their life, the leaders are more likely to perceive the need for external services. Impact could be due to the severity of the behaviour, or the length of time the behaviour continues for. Ben described an example of a congregant who presented with severe behaviour:

*Ben: "She had a crisis and I was there when she went. She cut all her hair off ... she had lost a baby, that is what finally tipped it over. Therefore, in some ways it is taken out of your hands, well it was, because we called the ambulance and, erm, we called the doctor straight away ... she was sectioned. So she was in the unit within a couple of hours. She is well now".*

As mentioned previously, Steven had an experience of aiding a congregant with schizophrenia. The congregant's state was severely impacting on his wellbeing when he was found curled up in the porch of someone's house foaming at the mouth. Tom had several experiences of meeting people who behaved in an extreme manner, such as displaying sexual disinhibition and thinking they were the devil.

Several of the leaders had a perceived need for mental health services because they valued the services' ability to contain risk, or take responsibility:

*Tim: "I just let them [mental health services] get on and do what they do and we never encourage people to do things against their judgement or to do it and not tell them, we want to be quite responsible with that really because it is a really big deal because mental health in my estate in my community can often end up with people ... you know if it goes wrong it can go very wrong, you know suicide attempts sort of wrong and that is massive isn't it?"*

*Ben: "You know if we are counselling someone who is clearly suicidal and then they commit suicide, which has never happened but they have family who are not in the church here and the family realise we were knowing that and say 'we were wanting them to go to a psychologist you would not let him go and you said no it's a spirit*

*problem'. Well that is not only folly or wrong I just think we can't afford to be seen as quacks ... we do not want to get caught with any litigation"*

Tim and Ben both held strong spiritual explanations for mental health difficulties, yet extreme behaviour was enough to override any concerns they had regarding accessing mental health services. The duration of the distress, or when the congregant's behaviours do not go away also significantly impacts a congregant's life, leading the Church leader to consider that services were needed:

*Owen: "I suppose when it becomes life limiting or begins to impact on their 'normal life' where it begins to take over ... We all go through times where we don't feel good about ourselves or life, but we come out of the other end ... I suppose it's where you see somebody who is dealing with a very difficult set of circumstances and you can't see the end to it ... if people are not progressing along the grief process in the way that you hope that they would then you need that intervention".*

Rhys highlighted how both extreme behaviour and behaviours which do not go away increased his perceived need for mental health services:

*"It would depend on the seriousness of what I saw as the mental health problem ... I mean, for Ron, harming himself, self-harm, was really serious ... But for me, Fiona, she seems much more serious to me. From the fact that she won't go and talk to somebody. That she won't try and deal with it. Even though she's not harmed herself, she's not tried to kill herself or anything like that ... it's just ongoing and ongoing and she won't deal with it ... For me I think that's why it seems more serious".*

Rhys also illustrated the position church leaders may find themselves in, where they feel mental health services are required but the congregant is not willing to access help.

### 3.2.3.3 CATEGORY: POSITIVE EXPERIENCES OF MENTAL HEALTH SERVICES

Several of the leaders had positive experience of mental health services and professionals, and due to these experiences, seemed to perceive a need for mental health services. Ben, Steven and Ed described congregants receiving support from the church whilst attending mental health service appointments. Ben described a woman in the church who misused alcohol and was attending a counsellor within the NHS; the woman was keen for a church leader to be present at her appointments with the counsellor:

*“One of our pastoral team actually goes to the counsellor with her. The counsellor likes her to be there and she just sits whilst she is going through these sessions”.*

Ben did not perceive a “clash of philosophies” in that situation and felt:

*“The professionals then were quite, err, appreciative of what we are doing, that we were providing an emotional - they probably wouldn’t call it a spiritual - an emotional need for them that was helping them. And I was happy to go along with that”.*

Rhys and Steven also had the sense that “a lot of professional people are very respectful of people with faith”.

Steven spoke of a leader in his church, who was also a GP, who had supported three congregants in attending psychiatrist appointments. Steven described the church being able to offer that type of support as “wonderful”. Steven also attended an appointment himself and was very encouraged by the experience:

*“The church member had said to the psychiatrist that she’d like her pastor to be with her and I did wonder how they would react to that but they were absolutely fine ... I think they could see that her relationship with church was beneficial in her case which was very encouraging because I think a lot of psychiatrists have severe doubts about people’s involvement with faith communities. So I was really encouraged by that actually”.*



Ed had experience of supporting a congregant whose psychiatrist was a Christian and was willing to allow Ed to be involved in sessions.

*"The lady [with a diagnosis of Schizophrenia] she... had a Christian psychiatrist who supported this patient and I think approached it from her own spiritual belief and faith ... we kind of worked with her in dealing with this lady who had quite severe psychotic episodes. We certainly worked with her on that occasion".*

It seemed that this impacted both the church leaders' and the psychiatrist's ways of working. Ed described one challenge of supporting congregants with mental health difficulties was they often got "support from different pockets" and that those pockets were not always able to talk to each other:

*"I think it was a case of not always being honest about what was being told to them (the congregant) ... if you can actually close that loop or talk to the GP directly you actually get a much clearer picture".*

The majority of church leaders had positive experience of mental health services, including when visiting a congregant on a psychiatric ward. However, the leaders differed on whether they chose to make their role as a church leader visibly obvious. Clive "displayed a Bible" to let people know his role and said, "I don't have many problems, you know, once they [the staff] know I'm a minister". Ed, however, did not wear a clerical collar, or display a Bible. He was glad of his anonymity because he thought:

*"they [ward staff] are also aware of course, that a lot of them, [patients] have religious delusions and you [as a church leader] may well be contributing to that. So I think psychiatric staff get a bit cynical".*

Lisa had an experience of a congregant where services had not helped at all, which may have impacted on her perception of the lack of need for mental health services:

*"A woman, she had had that help [mental health services] but she just felt they didn't know what they were doing but when she came to us I don't think she felt like we knew what we were doing either, so ... she just wasn't happy. I mean she got more from what we were saying to her because it was spiritual, but, umm ... she didn't feel she was progressing that much from what she was receiving from outside".*

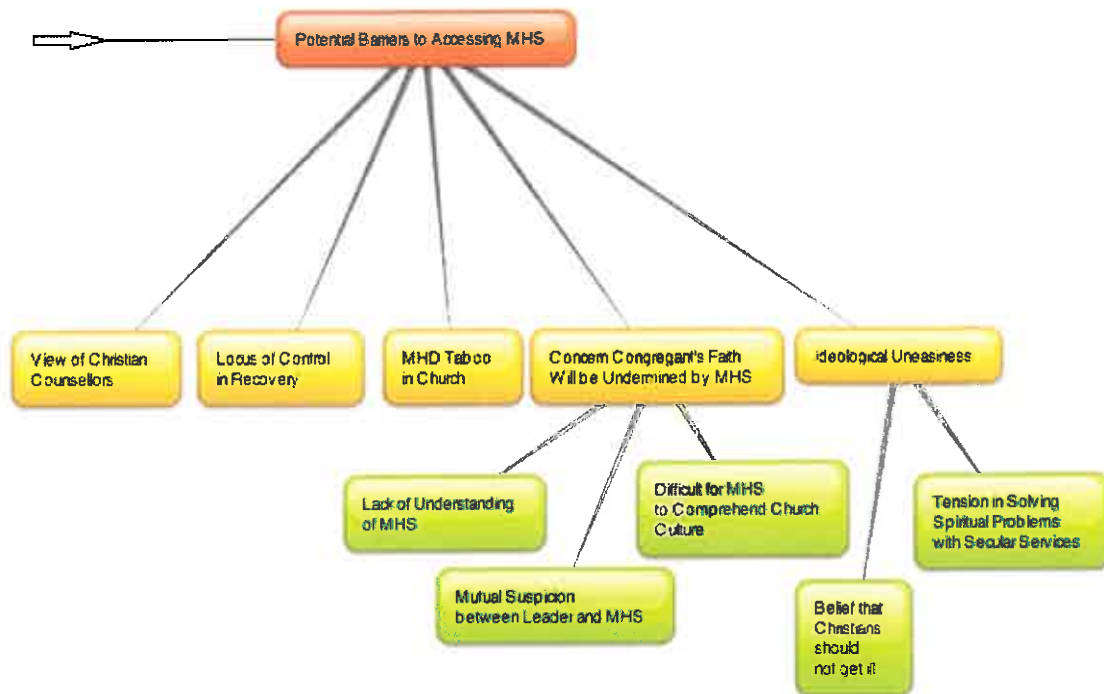
Lisa was also aware of her lack of experience with people who had accessed services outside of the church:

*"I am sure people have worked through their issues without God in their lives ... I am sure that has happened. But you know ... I am sure it has always been there in the back of their mind and thinking will I regress back or ... I don't know. Maybe you could show me someone who hasn't [regressed back] and I would be like 'well, I am glad because mental health is horrendous; it is horrible because it is hard to get treated for.'*

### 3.2.4 CORE CATEGORY: POTENTIAL BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

A range of church leader's experiences and feelings could be collated as 'Potential barriers to accessing mental health services'.

**Figure 3.5: Diagrammatic representation of 'Potential Barriers to Accessing Mental Health Services'**



#### 3.2.4.1 CATEGORY: VIEW OF CHRISTIAN COUNSELLORS

Half of the leaders were keen to suggest that congregants who needed support outside of the church should attend Christian counsellors. Such counsellors were seen as intermediaries between the church and mental health services with the large benefit of sharing the same Christian beliefs. Tim said that he would not refer a person to mental health services in a crisis (unless they were already attending) because:

*"It would be [a Christian professional] every time, because they know where their [the congregants'] need ultimately lies and where their hope ultimately lies ... the medical profession, I'm sure they understand but I just don't think that they understand the spiritual dimension of what we are doing if they are not Christian".*

Lewis felt that Christian counsellors were the first choice after church based support:

Lewis: "*[A] Christian counsellor is the obvious thing for us ... because they ... have a slightly different worldview and are coming from a slightly different place. If you believe that the spiritual is involved with virtually everything it is very different to believing that it isn't.*"

Christian counsellors were also seen to be able to understand the additional pressures of being a Christian:

Owen: "*I think most Christians would benefit from a Christian counsellor, just to understand that faith perspective on mental health, anxiety and depression. That can bring its own pressures that maybe somebody without a faith at all would find it difficult to get a grip on.*"

Some leaders, like Rhys, were not certain about Christian counsellors, fearing that they would only want to talk about faith issues and not mental health:

*"I am quite hesitant about referring people to somebody who ... pushes their Christianity before their professional status. "I'm a counsellor but I'm a Christian. No I'm a Christian counsellor" ... I'd hate to put anybody in with somebody who has got an axe to grind. You know? To do with their faith ... as opposed to dealing with this person's mental health problems."*

Ed, who often suggested people attend Christian counsellors, also expressed some reservations about them:

*"We are quite careful of what 'Christian counsellor' means. Some people think if you have done a couple of weekends at Waverley Abbey [short training course] or something [you are qualified]. So I prefer to know that someone has got some sort of proper background and training in counselling."*

### 3.2.4.2 CATEGORY: LOCUS OF CONTROL IN RECOVERY

Several leaders made reference to the degree to which they felt the congregant was responsible for their own recovery. Lewis described the individual's responsibility in choosing to make changes, he said:

*"People often develop a victim mentality which means that they struggle to be able to make their own choices and get kind of disabled. Then they maybe look to other people to make choices for them, because they don't want to take responsibility for their own life".*

Tim: *"You can take a horse to water but you can't make it drink. If they are telling you "this is how I am" but with no sense of "can you help me?", then you can't really do a great deal, especially with adults."*

Ben strongly felt that the congregant had the ability, when facing difficulties, to choose *"whether they overwhelm you, or if you have the ability to overcome those things"*. Ben had suffered a life threatening illness in the past and applied this principle of choice to himself:

*"I actually thought, 'will I die?' ... but I had to decide- it was faith ... I was often asked my mental state, as I was going through recuperation over the next few months- was I depressed? Was I worried? By the medical staff. But to be honest I didn't ever have a moment when I got depressed. I think it was because of my faith ... which says, "no, I can overcome this" ... I surrounded myself with people who spoke positively to me, rather than people who would say to me, "well now you are going to be an invalid for the rest of your life".*

Ben's experience had confirmed to him the possibility of choosing to get well. When congregants did not get better this caused Ben, on occasion, to *"get frustrated to think ... some people ... erm are not enjoying their bad health, their ill health, but don't help themselves enough to get better"* (Ben).

### **3.2.4.3 CATEGORY: MENTAL HEALTH DIFFICULTIES ARE A TABOO IN CHURCH**

Several leaders described how mental health difficulties were not discussed *“in church, or the circles I move in, it’s not something that is widely talked about”*. Tom, the eldest church leader interviewed, said that over his entire career: *“The problem of dealing with mental health problems has never ever been raised in any of those forums, either in the Bible school, in minister’s leadership programmes, in other church leadership programmes I have been involved in, or particularly here amongst my own team”*.

Conversely, Steven’s church had made an overt effort to tackle the stigma within church:

*“There seems to be some sort of stigma attached to being ... not admitting your weaknesses and frailties and we’re trying to break down those barriers in our church. We’re trying to encourage people to be real”*.

Rhys wondered if mental health difficulties were a taboo because *“it’s not been recognised before. That people, you know, within our congregations do have mental health problems.”*

Clive felt similarly: *“Until you come face to face with it you’re unaware and because you’re unaware it’s just not on the radar. Don’t even think about it. The thing about mental health in the church is until somebody comes face to face with it ... It just is not on their radar.”*

### **3.2.4.4 CATEGORY: CONCERN CONGREGANTS’ FAITH WILL BE UNDERMINED BY MENTAL HEALTH SERVICES**

Many leaders had worries about what would happen to a person of faith if they were to access mental health services. The concerns seemed to be based on a lack of understanding of mental health services, mutual suspicion between the church

leaders and mental health services and the leader's belief that mental health services would find it difficult to comprehend church culture.

#### **3.2.4.4.1 Subcategory: Lack of understanding of mental health services**

Several leaders talked about being unsure of what mental health services do:

Ed: *"I think it would be helpful to know how mental health services fit together, who does what. It would be helpful to know that sometimes they are not just stabbing in the dark as well when they are treating people with mental health difficulties ... We confuse the terms 'psychologist', 'psychiatrists', 'psychotherapy'. It doesn't always make a clear picture of what that is".*

Clive too was unsure of who does what, and had never really considered recommending mental health services before:

*"I don't think it has crossed my mind to [tell someone to] go and see a psychiatrist ... it is something that I don't encourage, I don't discourage. I would discourage taking anti-depressants. I don't really know what a clinical psychologist does ... so I've never referred anybody to a clinical psychologist. I've referred them to counselling ... and yeah I've not really ... given it much thought".*

The interview process for this research brought clarity for some; Owen found the research interview had motivated him to look for information:

*"What this has done for me today is crystallised ... you have done your job well to that extent, highlighting that mental health is an issue, it has got many facets but I wouldn't have known where to go if somebody had presented themselves to me. I need to find out what those external mechanisms are so we can generally point people in the right direction when we can't cope with it ourselves".*

Ben had found a conversation with two psychiatric nurses had helped him *'realise the service that mental health can offer'*, he also highlighted how challenging the lack of knowledge can be:

*"Sometimes I think we are left a little bit whistling in the dark thinking, 'what can we do here'? 'Where can we start'? 'Who do I call'? I know there is a GP and things like that but I think generally if we knew what was available for people that would help us because maybe it is a closed world like ours, is a closed world you go into. Maybe if we knew more about what mental health is all about and what it is trying to do? Is it trying to maintain? Is it trying to heal?"*

Clive, Ed and Tom felt that the churches lack of understanding of what mental health services do was due to the *"lack of dialogue"* between mental health services and the church. Ed felt services should *"give [churches] some guidance on how we could work more effectively in cooperation with them"*. He thought the guidance was justified, as churches *"probably spend more time with people with mental health than any other one organisation."*

#### **3.2.4.4.2 Subcategory: Mutual suspicion between church and mental health services**

Half of the leaders felt wary of mental health services and some thought that services were suspicious of them too:

Ed: *"People are very suspicious talking to people who deal in areas of faith, what they regard as spiritual"*.

Tim wondered if mental health services would not approve of Christian practices:

*"The medical profession ... I just don't think that they understand the spiritual dimension of what we are doing if they are not Christian. They might question the wisdom of us praying with people, of us pointing people to the Bible and encouraging them to believe those truths"*.



The mental health Chaplain thought staff in inpatient settings were suspicious due to the number of religious delusions they have encountered in patients:

*"Mental health professionals are like policeman, terribly suspicious because they have only seen the bad, nurses and some doctors are the same".*

However, Clive was the only leader to admit to warning congregants against mental health services:

*"I just give a word of caution, if they are seeing a psychiatrist, if it comes up; I say 'you just need to be wise'. Sometimes people don't always tell me".*

Tim said that if he felt that mental health services were actively opposed to Christianity, he too would say something:

Tim: *"We would never tell someone 'don't go and talk to them unless they are Christian' but if that person was saying 'part of your problem is God, forget religion' then maybe I would say 'hang on a minute that is not good advice' and if they started encouraging them away from church, away from the bible and proactively trying to compromise their faith then I would [tell them not to go]".*

Ed had experienced a reticence from GP's in forming relationships:

*"I don't think it is easy as a pastor to form easy relationships with GPs, I don't think they regard ministers, pastors as, errr, I don't know, people that add value to members of the community they may well be caring for. That can be a source of frustration because you will often be trying to refer people".*

#### **3.2.4.4.3 Subcategory: Difficult for mental health services to comprehend church culture**

During the interviews the leaders' perceptions of the difficulties that people who were not Christian had in understanding the Christian culture were discussed when the researcher asked if it made any difference knowing that she was a Christian.

Ben referred to Christian culture as removed from mainstream society: *"a closed world like ours is a closed world. It's that you go into this world, don't you?"*

As part of *'this world'* five of the leaders spoke about the *'lingo'* Christians used:

Ed: *"I probably didn't have to interpret my answers into a language that a person without faith would understand. I have tried to be careful anyway, but I think there is a degree of understanding that you would appreciate where we are coming from, as a person of faith, so that there would be a sympathy there with values and beliefs and a world view that understands in a belief in a God that wants to bring healing and wholeness to people lives".*

Lewis was unsure whether he would have been open with someone who was not a Christian as he presumed that they would not understand his experiences:

*"I think it would have been harder to talk openly about faith if you weren't a Christian because there is always a bit, you are trying to couch what you really believe in slightly different terminology but because you have an understanding of faith. I think it makes it easier to talk to you openly about it. I don't know if I would have done it if you weren't a Christian. There is motivation, isn't there, because some want to slam the church? So if it had maybe been a non Christian ... you may have been trying to drive towards ... Christians are all nut cases-they believe in a spiritual world."*

### **3.2.4.5 CATEGORY: IDEOLOGICAL UNEASINESS**

This category captures the sense of uneasiness church leaders express when their Christian set of beliefs conflict with their life experiences, or choices they need to make.

#### **3.2.4.5.1 Christians should not get ill**

Several leaders spoke about the tension between the belief that Christians should not get ill (held with varying degrees of openness depending on the church).

Lisa believed illness should never happen:

*"If my relationship is right with God then it [illness] would never happen. But you know you can always slip as a Christian, if you are not going forward you are actually backsliding".*

Rhys was very aware of the belief:

*"It's like, when you're ill and you're a Christian, people think that you shouldn't be because you're a Christian. And life don't work (sic) like that, does it?"*

This created tension because being ill could be interpreted as a lack of faith or the presence of sin in ones' life. Even when church leaders did not hold the belief they were aware of its presence in Christian culture at large. For example, the belief that Christians *"don't believe they should be struggling or suffering"* was raised by Owen. Ed thought that belonging to *"a community which perhaps holds values or ideals"* sets people up to feel pressure *"to wear a mask"*. The same phrase was used by Steven and Clive.

Both Ed and Rhys had personally experienced other people blaming their family members with long-term sickness for being ill and not being healed:

Rhys: *"Somebody said, 'That's not God's plan for you. God doesn't want you to be in this state. You've got to pray for healing'. It's like a particular person has put her*

*down because she's not been healed. I think that is awful. I mean, if I could say why God healed some people and didn't others ... I don't know why that happens. It just does happen, doesn't it?"*

Rhys believed the belief persisted because it silenced people:

*"People think 'if I'm a Christian, why am I having mental health problems'? I think a lot of people think as Christians you're going to be sort of super heroes. And it's not like that ... but we won't talk about it, because I don't think that this should be happening to me".*

The Chaplain said that his daily experience working in an inpatient setting challenged the belief that Christians do not get ill:

*"Perhaps Chaplain's deal with it more because we are dealing with the sharp edged suffering all the time. If we have a construct where it was all good or all bad then life would be quite easy ... good people would be well and bad people would be ill. But you couldn't have that because we know that that is not true, we have some wonderful Christians in the mental health unit but they have mental illness, they have depression, they have psychotic episodes and they are no less Christians".*

#### **3.2.4.5.2 Subcategory: Tension in solving spiritual problems with secular services**

Some leaders expressed uneasiness between having a belief that mental health difficulties have a spiritual cause, believing that God can heal people and then recommending congregants access a secular mental health service.

*"So do I think it is alright to take anti-depressants? Yeah I think that is fine, that is great. Can God heal people? Yes as well". (Lewis)*

Lewis, Ben and Tom condone both spiritual and secular approaches to supporting mental health difficulties. An element of cognitive dissonance could be detected as they tried to combine the two approaches:

Ben: *"It's a fine line you walk because you believe in faith and you believe in the power of the gospel to heal, which it does. But you also have to know that, err that God is not against medicine or medical professions"*.

Tom felt the need to justify the spiritual approach, when talking about recommending mental health services to congregants.

Tom: *"I think it is having the sense and the awareness that there are people in the world who are mentally sick, and without as a pastor decreasing the value of prayer, there are times when we cause them more damage by laying hands on ourselves<sup>9</sup>, instead of taking hands off and referring them to somebody who is competent to deal with their problem"*.

Supporting secular care, whilst holding spiritual beliefs, led some leaders to feel they might be judged negatively:

Tim: *"She has chosen to try to cut down anti-depressant usage ... perhaps it is just me being faithless, some more charismatic Christians might say, but I am quite happy to leave that between her and the Lord really. I won't tell her what she should and shouldn't be doing. When I know someone has tried killing themselves in the past and she has got young children, as much as I believe God can deal with her issues, I'm not going to be the one to tell her 'jeopardise your kid's parenting' against the better judgement of medical health professionals"*.

However, Lisa believed that mental health difficulties are a spiritual problem, therefore secular mental health services would be of no use, due to entirely omitting any spiritual dimension. Her beliefs were also confirmed by the fact that counsellors

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<sup>9</sup> 'laying on of hands' is a biblical term where people place their hands on someone whilst praying for healing for them.

within her church, who work in secular mental health services, have told her they have limited success in mental health services:

*“The problem is it is the spiritual attack on people’s lives [that is causing the mental health difficulty] ... And I’ve known counsellors who have said it [secular counselling] is like banging your head against a brick wall. You can only take them so far, you can’t mention spiritual matters ... you know that if you could just pray for them they would be totally released. But you are not allowed to do that.”*

This area did not cause uneasiness for Lisa as her actions cogently followed her belief regarding the concept of mental health difficulties.

Steven, however, had a sense of the danger of relying on spiritual healing alone and ignoring mental health services:

*Steven: “I think you get into very dangerous territory if you start saying to people, “Don’t go and see your psychiatrist because they’re not a Christian, because what they’re going to advise you is not necessarily helpful.” I think you could almost be complicit in someone’s demise, at its worst. For example, you know, if you said to someone who’s suffering severe depression, “Stop taking your antidepressants,” that is pretty dangerous territory.”*

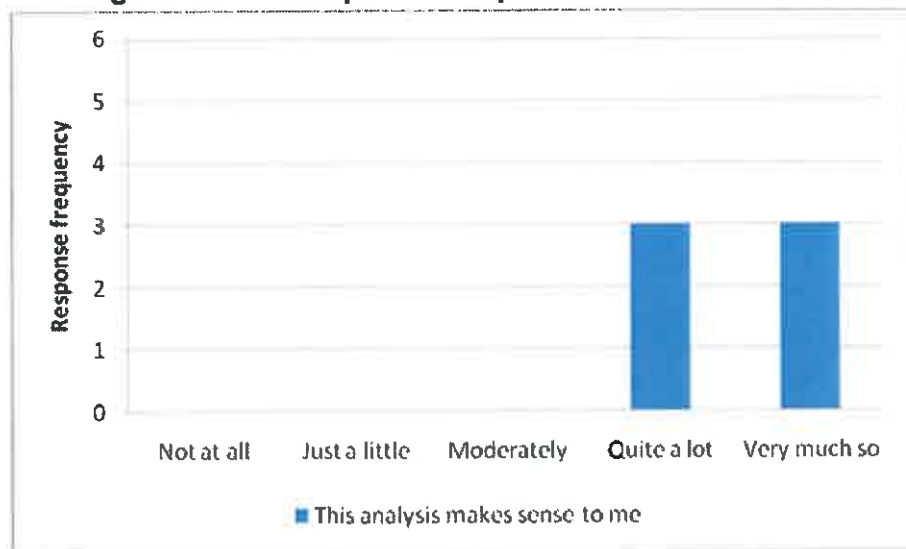
### **3.3 RESPONDENT VALIDATION**

After the analysis of the ten interviews were drafted, respondent validation was employed. A brief version of the analysis was emailed to the church leaders and they were asked to respond on a 5 point Likert scale in accordance with how much they agreed with the following statements. (Response options ranged from ‘Not at all’, to ‘Very much so’):

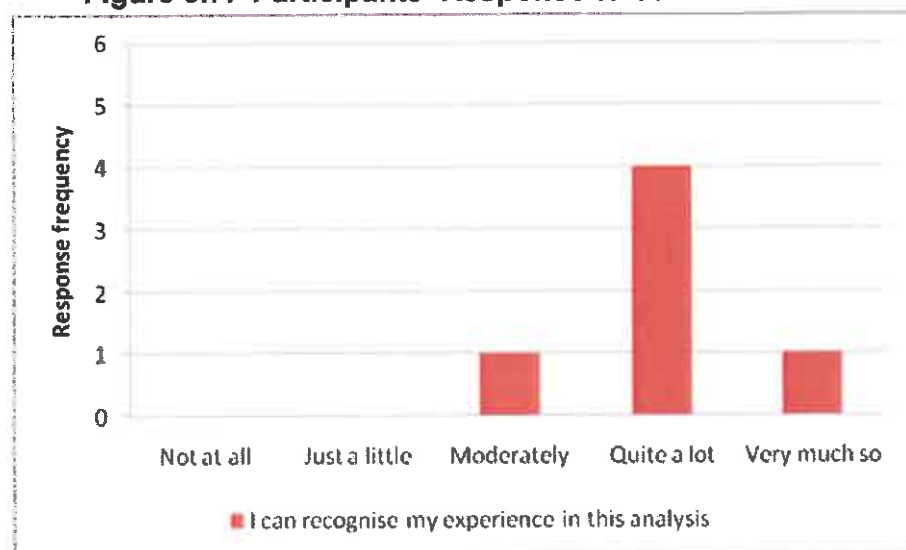
1. This analysis makes sense to me
2. I can recognise my experience in this analysis
3. I think the understanding provided by this analysis will be useful to me

The participants were given three weeks to respond. Six church leaders returned feedback and responded as below. The feedback suggested that generally the leaders did understand the analysis; they recognised their experience in it and it was thought to be helpful.

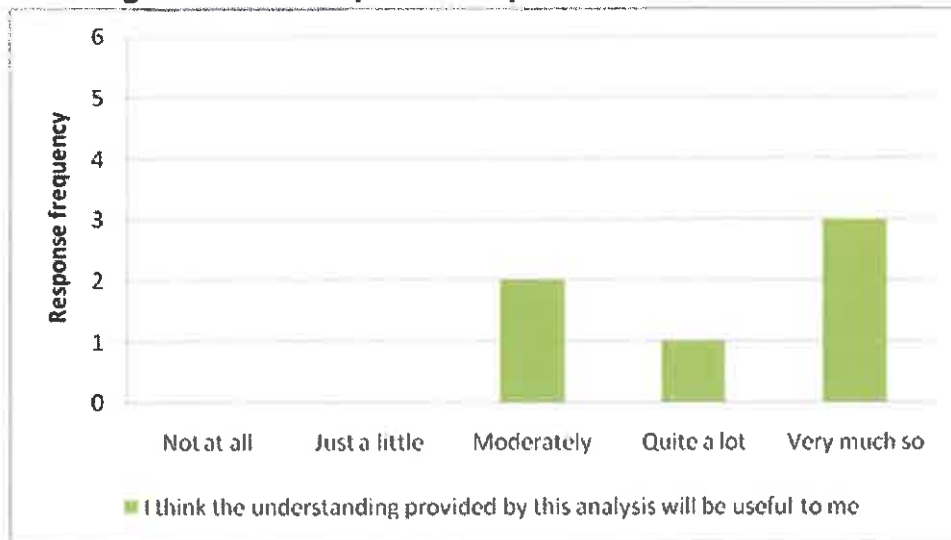
**Figure 3.6: Participants' Response to Statement One**



**Figure 3.7: Participants' Response to Statement Two**



**Figure 3.8: Participants' Response to Statement Three**



### 3.4 INTER-RATER RELIABILITY

Inter-rater reliability was utilised (see 2.11.3) and the results are shown below in Table 3.1. This highlights the level of agreement between the manner in which the researcher categorised the data from the interviews and the categorisations made by the raters.

**Table 3.1: Percentage agreement with the author's categorisation of randomly selected excerpts**

Rater description	Percentage agreement
Psychologist (Atheist)	100%
Psychologist (Hindu)	93%
Non-Psychologist (Christian)	100%

Due to the high level of agreement no statistical analysis was applied. The degree of agreement between raters and the researcher could be due to the categories being very descriptive. However, it also suggests that the categories are recognisable to both psychologists and non-psychologists, people who have a religious faith, or none.



A tentative model of how church leaders decide how to support individuals with mental health difficulties can be found in Appendix 14.



## CHAPTER 4: DISCUSSION

### 4.2 RESEARCH FINDINGS AND THEIR RELATION TO THE EXISTING LITERATURE

#### 4.2.1 LEADERS' CONCEPT OF MENTAL HEALTH DIFFICULTIES

The ten church leaders in this study held varying views regarding what causes mental health difficulties. Two leaders felt that mental health difficulties were predominantly spiritual. The remaining eight leaders gave suggestions regarding aetiology which included social, biological, psychological and spiritual frameworks. The leaders also discussed what they believe to be the protective elements of having a faith.

##### 4.2.1.1 *Causes of mental health difficulties*

Heider (1958) described the lay-person as a 'naive scientist', linking observable behaviour to unobservable causes. Heider described the 'naive scientist' as deciding whether a given action is due to something within the person who is performing it (e.g. intention) or to something outside the person (e.g. difficulty of the task). Understanding what set of factors should be used to interpret behaviour will make the perceivers' world more predictable. Therefore all the leaders held an explanatory model covering the causes of mental health difficulties. The majority of the leaders alluded to all elements of the biopsychosocial model of mental health difficulties. "Philosophically, this model enables understanding of how suffering, disease and illness are affected by multiple levels of organisation, from the societal to the molecular" (p.576, Borrell-Carrió *et al.*, 2004).

In addition, all of the leaders felt that mental health difficulties have a spiritual cause, but varied on whether they considered the spiritual element to be proximal to the problem, or distal. Two of the leaders spoke about a proximal spiritual cause, the devil, which was in line with Lowenthal's findings (1996). It was not clear in conversations about the devil whether he was seen as a cause of mental health difficulties, or whether he was perceived to get involved with the person as a

consequence of their mental health difficulties. In fact, within the same explanation some leaders referred to him being both. Despite the increase in attention paid to spirituality, psychological research into the concept of the devil is scarce (Jensen, 2009). No research papers could be found on what psychological function the concept of the devil may have for those who have discussed it. However, the biopsychosocial model has been expanded to include a spiritual element (McKee & Chappel, 1992) which could begin to place these beliefs in a framework which makes sense to non-religious clinicians.

In the current study, one of the ways the leaders felt the devil could cause mental health difficulties was through negative speech. Ben and Lisa both taught within their church on the importance of what Christians say. Negative words were seen as being able to 'cause' negative things to happen.

*Ben: "I have known someone who talked themselves into a wheelchair because they said 'I am going to be ill. I am ill' and they went into the wheelchair. The doctors said 'really there is not much wrong with you at all'. They said 'no this is where in am going to be now and they were in a wheel chair for 20 years. No matter what is prayed for them or taught to them they said 'yes, well this is how it is going to be'. It was sad. I do believe, not a demonic possession, but I do believe there is an enemy of our faith who wants to destroy people".*

This belief is accepted within some churches, and in others not mentioned at all. The explanation for how negative speech could cause negative things to happen varies, and is not always discussed in detail within churches. One reason is that it offends God, because negative words are not 'words of faith' and therefore are 'not in line with God's word' (the Bible). An alternative explanation is that "by speaking negatively, you are giving the devil permission to come and steal, kill and destroy your life"<sup>10</sup> (Okolo, 2010, p.21). A final explanation is that Christians should not speak negatively because of the impact it can have on your outlook:

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<sup>10</sup> The bible says "Resist the devil and he will flee from you" James 4:7. Some believe a way of 'resisting' is speaking in line with the positive things the Bible says.

“The more you talk about something, the more you magnify it ... When you are always talking about the negative things in your life ... you will stay down and discouraged” (Kelsey & Kelsey, 2010).

Although culturally, speaking negatively is explained differently, there is some evidence in cognitive behavioural therapy that the repetition of negative comments does impact the type of information that is absorbed from the environment and retained. This in turn, influences the individual’s beliefs about themselves, their emotions and their behaviour (Beck, 1987). However, the key element for two of the church leaders was the spiritual link in the chain between thought, spoken word and behaviour. At times, this process was referred to as being something ‘the devil could use’.

This example highlights the usefulness of qualitative approaches in adding richness of narrative. If quantitative research had been employed in this instance, these leaders could have been given a questionnaire item asking if they thought that negative beliefs could cause mental health difficulties. They would respond yes, but their concept of how negative thoughts impact people would be entirely different to that of a secular psychologist.

Other leaders considered the spiritual causes of mental health difficulties to be related to the absence of God in a situation (e.g. through not reading the Bible enough), rather than the influence of evil. This was felt to impact on mood, and therefore mental health. Many leaders also thought guilt, related to not meeting God’s and other congregant’s expectations, was a psychological cause of mental health difficulties.

Findings are mixed regarding whether guilt is higher amongst those who are religious. Lukyten *et al* (1998) did find that religious people experienced higher levels of guilt, but this was not pathogenic, as research suggests that it is shame (rather than guilt) that leads to mental health difficulties (Andrews *et al*, 2002). However, if there is a set of religious expectations that the individual fails to meet, this could cause guilt (see 4.2.4.1 for further discussion regarding the belief that Christians

should not get ill). Christian perspectives on psychological difficulties, such as the spiritual meaning attributed to behaviours discussed here, are rarely touched upon in psychological literature. Therefore, how these issues should be broached clinically remains unknown.

#### ***4.2.1.2 Impact of the leaders concept of mental health on support provided***

One of the church leaders with the most cogent concept of mental health difficulties was Lisa. She had a clear sense of what causes mental health difficulties (spiritual attack on the individual) and what needed to be done about it (the individual needs prayer). She also believed that a lack of recovery was due to the individual not wanting to let go of their sickness identity. The cogency of her concept of mental health difficulties may have reduced the cognitive strain others seemed to experience when thinking about these issues. Nonetheless, she did admit that her church had limited success in supporting people with mental health difficulties. Other leaders seemed to experience more cognitive dissonance as they combined spiritual and biological, psychological or social causes (see 'Ideological Uneasiness', 4.2.4.1), or held several types of explanations simultaneously (Williams & Healey, 2001).

Steven was another Church leader with a cogent concept of mental health difficulties. At the other end of the continuum from Lisa, Steven held a biopsychosocialspiritual explanation for mental health difficulties and therefore felt that the mental health services were complimentary to the role of the church. Steven was the only leader interviewed whose church had a designated mental health branch of the church ministry, with its own subset of leaders, in which Steven was the senior leader. The church had its own mental health training run by a medical professional and mental health professionals were invited. Steven and those working with him within the church had attended doctors' and psychiatrists appointments with congregants and had supported people through the sectioning process as well. Comparing what the church leaders in this sample reported his church seemed to have the largest number of congregants with severe and enduring mental health difficulties. Steven was unsure why this was the case:

*"It could be because we're willing and able, and hopefully in some ways equipped, that God is putting people with those issues in our path. I can't find any other logical explanation for it ..."*

In comparison, Lisa, who thought that all mental health difficulties were spiritual, said that those who did not recover left the church. It could be tentatively suggested that those churches who are accepting of peoples' struggles with mental health difficulties attract more people with similar difficulties. Those, as Baker (2010) found, who exhaust the explanatory model of the church, feel rejected by them and leave. Closely related to this area, Waller (2010) is at the consultation phase of attempting to compile a list of 'mental-health friendly' churches as a resource for congregants. Such a list may also highlight some of the key elements of churches that support people with mental health difficulties well.

Experientially, all of the leaders knew a friend or family member who had suffered from mental health difficulties. The researcher was intrigued that none of the leaders chose to speak of their own mental health difficulties, except for Clive, who spoke about feeling depressed, but this was before he became a Christian. It is not clear whether this was due to concern about the researcher negatively evaluating them, or related to the expectation that leaders should be able to cope, or that in the sample of leaders, no one had any history of mental health difficulties. Nonetheless, Tim's wife strongly believed that it was *'God's grace'* that kept her alive and brought her out of a psychiatric ward. This confirmed to him the solution to mental health difficulties (leading people towards God) and strongly impacted how he works in the present.

It seems that friends and family members' experience of mental health difficulties does feed into the leader's concept of mental health difficulties. For seven of the leaders it resulted in increased empathy and understanding. For three others it tended to confirm what they already knew, that mental health difficulties are spiritual issues and that faith and trying hard to recover gets people through. For example, Lisa spoke about her brother-in-law who had mental health difficulties; he was not a

Christian so his experience also confirmed her beliefs of a spiritual cause (as he '*did not know God*').

However, the 'confirmation bias' (Ditto & Lopez, 1992) suggests we seek information which confirms our beliefs and reject information which contradicts it. Charmaz (1990) discussed how robust individuals' constructions of illness can be, especially in groups of like minded people:

"Ill people's ... friends and family often support their constructions even when these constructions challenge or contradict those of the medical professionals and even when ill people cannot make their constructions credible or negotiable" (Charmaz, 1990, p1161).

One part of the leader's process of supporting a congregant with mental health difficulties appeared to be deciding how proximal, or distal, the spiritual cause was in the individual's presenting difficulty. Kramer (2007) called this a 'filtering' process whereby the leaders attempt to differentiate whether the difficulty is due to a mental health crisis, a life crisis, or a spiritual crisis. Kramer (2007) discovered this when studying American church leaders supporting congregants with depression but did not ask the leaders 'how' they make this decision.

In the current research, '*discernment*' was referred to as a way of deciding if a problem had a spiritual cause, as has been in previous research (Leavey *et al.*, 2008). Discernment is defined in many ways in religious and theological circles but has not attracted much research attention. One definition of discernment is "the process in which we examine, in the light of faith ... the nature of the spiritual states we experience in ourselves and in others" (Dubay, 1977, p.91) and is mentioned on numerous occasions in the Bible.<sup>11</sup> The decision which is being made in the current context is whether the individual's spiritual state is being impacted by the devil.

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<sup>11</sup> E.g. 1 Corinthians 12:10



Whilst acknowledging the manner in which Christians believe God can communicate with people Dubay (1977) is keen to reflect on the additional unconscious motivations which can impact upon the decision-making process in 'discernment'. In the current research the usage of the term 'discernment' varied amongst the leaders. Some saw it entirely as a spiritual phenomenon, while others used the term to describe a form of tacit knowledge which also incorporates elements of their previous experiences. It is this 'non-divine' element in discernment which is open to psychological reflection and development in respect to church leaders' decision about whether mental health difficulties are due to spiritual issues. Some familiarity with the concept of discernment would also be important for clinicians providing training for church leaders. Social support has been shown to be positively associated with psychological well-being (e.g. Myers & Diener, 1995). Furthermore, the social support that individuals receive from members of congregations and church leaders is deemed to be one of the key mediators between religion and mental health (Hill & Pargament, 2003).

The leaders also spoke about factors related to having a belief in God and attending a church, which they felt protected congregants against developing a mental health difficulty. Similar to Pargament *et al.* (1998), the leaders in the present study felt that having a secure relationship with God, a sense of hope and spiritual connectedness with others enhanced psychological well-being.

Research into social influence in small groups suggests that when a judgement has to be made about some aspect of reality two influences are taken into account. Firstly, if the individual agrees with the group they have undergone 'informational influence': they yield to others (e.g. the church leader) because they trust their judgement more than their own. Secondly, is the 'normative influence', where the desire to be liked by the rest of the group influences the judgement being made (Van Avermaet, 2001). In addition, some of the early studies on conformity such as Asch (1956) demonstrate the power of 'the group' to create distortions in an individual's perception of the world. These principles suggest some ways in which a church leader's explanatory model of mental health difficulties could impact a large number of people in a positive or negative manner.

#### 4.2.2 SUPPORT PROVIDED BY THE CHURCH

Churches are places where many people, including those with mental health difficulties, experience various types of support. Consequently, the researcher was interested in exploring the nature of the support church leaders provided and their rationale for providing it. Practical, spiritual and long term support was given, as well as support when a mental health crisis occurred. Mitchell and Baker (2000) found that clergy attract favourable comparisons with psychiatrists with people seeing clergy as individuals who offer care to the whole person, not just attending to the mental health difficulty. Church leaders in this research reported providing practical care to congregants, which was seen by some leaders as equally as important as any other form of care.

The leaders felt that spiritual support was the defining feature of the support they provided and the area in which they felt they had competence and authority. Consistent with Leavey (2008) most of the leaders avoided descriptions which could be seen as a belief in miraculous healing alone. Only Lisa and Ben described miraculous interventions from God.

Many leaders offered '*counselling*' as part of spiritual care where individuals could '*talk about their past*', '*let it all out*' and '*be encouraged to believe the truth about God*'. It seemed that in this setting positive religious coping was likely to be encouraged (Pargament, 1998). Half of the leaders differentiated between what they did and '*professional counselling*', referring to their version as "*pastoral counselling*", or "*just talking*". Rhys described how the notice board outside of his church had previously said that the Vicar offered counselling, but he requested that this part of the notice be removed, as he felt that it had professional connotations beyond his role. Others saw counselling as a skill that solely belongs to other professionals.

Many church leaders have one-to-one pastoral meetings and these are ideal settings in which to highlight the dimensions of religious coping which are not beneficial to the individual and most related to poorer mental health (Pargament, 1997; Pargament, *et al.*, 1998). These could include religious apathy and doubt, feeling angry at God or

punished by him, interpersonal religious conflict and conflict with church dogma. However, there are a number of problems with this suggestion. One is that church leaders are unlikely to be aware of the notion of positive and negative religious coping, which exists mostly in academic realms. In addition, some church dogma reinforces negative religious coping. For example, the belief that ill-health is caused by demonic influence.

Whether or not one-to-one spiritual or pastoral support alleviates mental health distress does not seem to have been researched in much detail. However, research investigating such an association could consider the church leader as a form of lay therapist, and hence be informed by Wampold's (2001) work regarding the common elements that influence effectiveness across different types of therapeutic interactions. These factors include the working alliance between the client and the therapist, the gaining of hope and the expectancy of improvement. All of these factors were mentioned by leaders during the interviews.

It is likely the pastoral relationship between church leader and congregant is established in a manner which may meet certain important psychological needs. In 2003 a National Advisory Group on Mental Health, Safety and Wellbeing was established to collate a set of universal and relationship-based psychological needs (Seager, 2006). The list they decided upon included: attachment and trust; empathic communication and relationship; identity and belonging; containment, security and discipline; value, meaning and purpose; resilience and self-determination; and satisfaction and pleasure. All of these needs were mentioned by the church leaders during the interviews, although not necessarily using the same terms.

The church leaders held a different perspective to that of most mental health services by including a spiritual component in both the aetiology and alleviation of mental health difficulties. Consequently, the researcher wondered what the experience of congregants, who simultaneously experience counselling from both the church and mental health services, is like. Clive said:

*"I'm always cautious because you know they'll come and see me [church leader] and they'll go and see a psychiatrist and probably, but not always, I'd have a different world view".*

One leader spoke about a lady with schizophrenia who was receiving both church counselling and mental health services counselling. If neither the church leader, nor the mental health professional acknowledges this, then the individual in distress may have the additional cognitive challenge of attempting to assimilate the information given by both sources.

#### **4.2.2.1      *Reasons for specific modes of providing help***

One of the research aims was to explore why the leaders provide the type of support they do. Little is known about this, yet it could have implications for how leaders and clinicians could work together to encourage mental-health friendly changes to church-based support structures.

All of the leaders interviewed had direct control over how they supported individuals, even within the churches with more nationally-influenced structures such as the Anglican or Baptist Church. Consequently, the leaders described how they set up their support structure within the church to reflect their values. Interacting in a way that reflected biblical values of love, acceptance and support was essential to the leaders.

In attachment literature the nature of being 'held in mind' by another during the developmental stage is seen as essential (Winnicott, 1958). It has also been suggested that the greatest risk to psychological safety for all human beings is to be forgotten and lost from view (Seager, 2006). Although beyond the scope of this research, it is likely that being known and accepted by a group of people within a church is therapeutic in itself. It is also possible that in providing this level of support, churches could be preventing the development of prodromal symptoms and distress which would, in time, require the support of primary care. Mind (2011) campaigned against the lack of talking therapies offered to people via primary care in Wales due to a lack of resources. The link was made between a lack of talking therapies and

high numbers of antidepressants being dispensed in Wales. It could be that where secure and established relationships are being built in congregations, a need which may not be fulfilled in the current mental health-care system is being met. Future research would do well to investigate this.

The desire to build a sense of community within the church was also discussed as a motivating force behind the type of support offered. Seligman (1991) suggested that the high rate of depression in society stems from impoverished social connections in increasingly individualistic Western societies. Research has suggested that those within congregations do experience a high degree of community and connection to others (Fiala et al, 2002, Ventis, 1995). The high value placed on creating community also hints at the presence of social support, which is consistent with previous research as one of the key mediators between religion and positive mental health (Hill & Pargament, 2003).

Another element that was reported to impact on the development of support was the congregants themselves. In particular, churches with people who had medical expertise, or interest in setting up specific support for people with mental health difficulties in the church, often suggested a new support structure and were generally given permission to create it. For example, in Clive's church a congregant had an idea for a pregnancy crisis centre, set it up and it now runs successfully and accepts referrals from local G.P's. These findings could indicate that further mental health training could be suggested by medically trained congregants, by national leadership training bodies, or by outside agencies.

In addition, the presence of congregants with mental health difficulties within a church often led to the revision and development of support structures. This is somewhat tautological and leads to further unanswered questions about what type of church someone with mental health difficulties is most comfortable attending and staying at.

### **4.2.3 PERCEIVED NEED FOR MENTAL HEALTH SERVICES**

Throughout the course of conducting these interviews it became apparent that the leaders varied in how much they perceived a need for, or valued, mental health services. This in turn impacted how likely they were to recommend mental health services (incorporating psychologists, psychiatrists and secular counsellors) as a form of support for people with mental health difficulties. One advantage of using grounded theory was that multifaceted responses from church leaders were able to be captured. The six church leaders who had previously had positive experiences of mental health services seemed to value services the most. Four leaders did not perceive a need for mental health services. Two of these said that they would not suggest a congregant even went to see their GP.

An additional factor that appeared to impact the extent to which leaders perceived a need for mental health services was how competent they considered they themselves were to support individuals with mental health difficulties. Many leaders spoke of feeling incompetent, implying that they had sensed that 'others' were competent. However, feeling undertrained did not necessarily result in the leaders thinking more about involving mental health services. This finding differs somewhat from that of Leavey *et al.* (2010) who consistently found that clergy's recognition of their own professional limitations was marked by a willingness to refer members of the congregation to professional help. Perhaps the clergy in Leavey's sample had all had positive previous experiences with mental health services. This is likely as a number of the clergy in Leavey's sample also had previous medical training. In the current sample it is not clear why feeling a lack of competence did not necessarily lead to recommending mental health services. One reason could have been because feeling that secular services did not fit with their belief system (linked to 'Ideological Uneasiness', see 4.2.4.1).

Some leaders spoke about the impact that supporting individuals with mental health difficulties had on their perception of their own usefulness as a pastor in general. Unlike mental health professionals who have specific training and formal supervision, church leaders spoke about supporting those in emotional distress, including at

times the dying and bereaved, with little training or support. Lloyd-Williams (2006) highlighted the way in which society expects clergy to be able to offer support, but does not always consider the clergy's own need for support. Although excluded from the main findings due to lack of space, many leaders discussed the impact of supporting those with mental health difficulties on their own emotional wellbeing. In addition, how difficult it could be to access mental health support for themselves as church leaders.

Another factor which impacted on the leader's perceived need for mental health services was their clarity regarding their role. Several leaders claimed they were '*not the expert*' in mental health. This appraisal had different implications for different leaders. For some it resulted in anxiety at not being useful, or about potentially making the wrong choice. Others had a clear sense of role boundary, and were resolved not to be the expert because being an expert in mental health difficulties was not their role. Lamont and Molnar (2002, p.180) proposed that "boundaries are markers of difference which make for separation and exclusion". They noted that boundaries between organisations serve to structure the allocation of cognitive authority and material resources.

On a contextual level, this topic represents the overlapping of two agencies, the church and the NHS, on the shared ground represented by the congregant. Gieryn (1999) coined the term 'boundary work' to characterise discursive practices by which demarcations or other divisions between fields of knowledge, are created, advocated, attacked, or reinforced. Academic scholarship on boundary-work has emphasised the fact that such delineations often have high stakes involved for the participants, and carry with them the implication that such boundaries are flexible and socially constructed. The notion of boundaries is particularly relevant to the study of professions, and specifically to how they have come to be distinguished from one another, such demarcations include experts from laypersons and science from non-science (Shuval & Mizrahi, 2004). When a church leader expressed clarity about their role and a clear sense of what it is they offer, they seemed to be able to better demarcate the boundaries of their role, and the role of mental health services.

The final element which increased, or decreased, leaders' perception of their competence was their access to mental health knowledge. The more knowledge leaders had regarding mental health difficulties, the more likely they were to perceive a need for mental health services. It was a surprise to the researcher to discover that the majority of churches have a number of medical congregants, with whom leaders consult, when deciding how best to support a congregant.

A few church leaders also utilised knowledge that they had either gained from previous training received in secular jobs, or through similar experiences with other congregants. The majority felt they had had no mental health training, including those who had been through some form of religious leadership training such as Bible College. This finding is similar to that in Oppenheimer *et al's.* (2004) review, where 20% of journals published between 1970 and 1999 on the topic of collaboration between church leaders and psychologists suggested that clergy needed more knowledge regarding mental health difficulties. This was discussed with the national leader who was involved with designing training for future church leaders. He said:

*"In most Christian leadership training, teaching on understanding mental health is a very small thing indeed. In the past there has been a lot of talk about training in counselling, though it tends to be about attuning people to having listening skills however much you dress it up ... most ministers would talk about themselves as listeners ... but as for skills to help people with specific [mental health] conditions they have to go outside themselves. I hope most people would see that. The point comes when it becomes an issue of boundaries and probably an insight into their own competence".*

The Mental Health Foundation (2007) suggests that faith community leaders need to develop their capabilities for understanding mental health problems and the needs of their community members. Some church denominations have made moves to provide training to increase mental health awareness. For example, the Methodist church recommends that a church leader takes a 10 week training course with teaching on how to recognise signs of mental health difficulties and how the local church can co-operate with medical and social work agencies. One difficulty with



expecting church leaders to source and **access** mental health training is the stigma they described. Mental health difficulties are seldom discussed in churches at local or national level. Therefore, changes in the availability of mental health training, or the prioritising of it in the schedules of church leaders is unlikely to happen, unless more frequent dialogue regarding mental health difficulties is had both within churches and between churches and mental health services.

One solution would be for churches to establish an expected level of competency for church leaders to demonstrate in supporting individuals with mental health difficulties and train leaders accordingly. Codes of ethics or appraisal procedures to assess church leaders' competency to support those with mental health difficulties are still at a relatively early stage compared to others who are in caring roles (Lynch, 2001). The Diocese of Oxford's (1996) Code of Ministerial Practice for 'all who exercise a recognised ministry within the church' states that 'those engaged in pastoral ministry should be ready to seek further help and appropriate training' (Diocese of Oxford, 1996, p.6). It also advised they should be clear about what they are able and competent to offer. This looks promising, but could be difficult to enforce. Furthermore, it is only applicable to Anglican church leaders in one area, and does not apply to church leaders from other denominations, non-denominational backgrounds, or Anglican church leaders outside of Oxford.

Two factors which seemed to increase leaders' perceived need for contact with mental health services were if the congregant's behaviour was thought to put them at risk of harm, or they had been receiving support and they were not seen to be improving. If behaviours such as severe self harm, attempting suicide or behaving erratically (e.g. shaving one's head) occurred, this seemed to override any barriers and the church leader would refer to services. When a congregant's mental health difficulties began impacting on their daily life some church leaders used this as a sign that further support was needed. It is possible that church leaders could act as a kind of triage, in this manner, for mental health **services** if better communication was established.

Throughout the interviews it was clear that the church leaders had encountered significant levels of risk, including risk to the congregant themselves, to others and to the church leader. Weaver (1992) wrote a guide for church leaders about how they could handle situations of risk they may face. However, it was published in an academic journal, which most church leaders would not have access to. The level of risk experienced is concerning especially in the light of the lack of training leaders report and the distress both leaders and congregants could experience. This warrants further research.

#### **4.2.4 POTENTIAL BARRIERS TO ACCESSING MENTAL HEALTH SERVICES**

The leaders recalled a number of factors that, if present, may make them less likely to recommend or encourage their congregants to access mental health services. One unexpected finding was that four of the leaders said if a congregant required support beyond the level that they themselves could provide, they would rather refer to a Christian counsellor than to mental health services. Christian counsellors were considered '*the natural choice*' because leaders thought the counsellors understood '*the spiritual dynamics*', the language the congregant uses and '*know about the gospel*'. As a result the researcher placed the role of Christian counsellors in the core category 'barriers to accessing mental health services'.

It is possible that having the option of referring to a Christian counsellor satisfied the leaders desire for accessing 'expertise' for the congregant, whilst also incorporating a Christian viewpoint. Engaging with questions such as 'why is this congregant not recovering?', 'why do I feel undertrained?', 'Am I able to recommend secular services whilst believing that God can heal?' could be bypassed by being able to refer to Christian counsellors.

Another barrier in accessing mental health services was church leader's attributions regarding the locus of control for recovery. Individuals make sense of the world according to the way in which they interpret and give meaning to events or experiences. Proposed causes – or attributions – for events have long been considered important mediators of mental health (Cornah, 2006). Some leaders believed that individuals have the control and the responsibility to recover from

mental health difficulties, if they chose to. Therefore, lack of recovery was seen as an over attachment to the 'ill' identity, or a failure to take responsibility. Believing a lack of change is 'the individual's fault', could prevent the church leader from using the feedback from the congregant to consider what other factors in the system could be impeding the individuals improvement. It is possible that the church leader who considers the congregant to have complete control over recovery may create a closed system.

Webster (2011) defines a 'system' as a "regularly interacting or independent group of items forming a unified whole, which is in, or tend to be in equilibrium". Rational systems perspective (Scott, 1998), which forms the basis of systemic thinking, differentiates between open systems which respond to feedback from the environment and closed systems which overemphasise principles of internal organisation and fail to develop and understand processes of feedback.

It is possible that a leader who holds an internal locus of control in recovery for congregants might not look objectively at the process the congregant has been through and the support offered by the church. The maintenance of high distress levels may be an indicator for some leaders in open systems that someone with more expertise is required. Conversely, if the congregant is held to blame for his or her continuing emotional distress then there is no need to reflect on what else in the system, such as teaching, type of support and so on, may need to change. Systems theory also suggests that systems are based on a set of rules, often unwritten. Rules about recovery are included in this and such rules were implicated in this research (McLeod, 2003).

Church leaders who thought it was the individual's choice to recover also seemed to feel more frustration towards the individual:

Ben: *"I think you can get frustrated to think, err some people.. erm, are not enjoying their bad health, their ill health, but don't help themselves enough to get better"*

Trice & Bjorck (2006) interviewed American Pentecostal church leaders regarding their understanding of the cause of depression. They found that leaders with a Pentecostal leaning are likely to presume that lack of recovery from depression was due to the depressed person not being spiritually devoted enough. Spiritual treatments such as reading the Bible and confessing sin were viewed by them as the most effective solutions. Trice & Bjorck's research suggests that clinicians working with clients with a Pentecostal worldview should be sensitive to clients' increased propensity to self-blame. As some of the church leaders in the current research were non-denominational and reported the same belief, the researcher would suggest it is worth bearing in mind increased likelihood of self-blame in formulation around any client with Christian views.

A further barrier to church leaders involving mental health services is that mental health difficulties appear still to be a taboo topic in church settings. The majority of leaders spoke about how mental health difficulties are not discussed in their church context either locally or nationally.

Owen: *"In church or the circles I move in, it's not something that is widely talked about"*.

This is consistent with a large scale piece of research conducted in 2010 by the Evangelical Alliance. The survey of 17,000 evangelical Christians covered a large number of topics described as creating '*A snapshot of the beliefs and habits of evangelicals in the UK at the beginning of the 21st century.*' However, the topic of mental health **was** not mentioned once.

When mental health is a taboo the experience of having mental health difficulties can be stigmatising. Leavey *et al.* (2007) sampled 32 clergy in London regarding their experience of supporting those with mental health difficulties. They expressed "low confidence about managing psychiatric problems, underscored by anxiety, fear and stereotyped attitudes to mental illness" (p548). Such fears were not expressed by the leaders in the current research. To a lesser extent, the use of biblical language referring to those with mental health difficulties as 'broken' or 'lost', portrayed a

sense of those with mental health difficulties as 'the other'. Labelling human variations in this manner can be the start of stigma (Link & Phelan, 2001). In churches where those with mental health difficulties are labelled as having less faith, or are seen as having been impacted by the devil, congregants may experience more stigma.

However, two leaders commented on the opportunity to talk about issues related to mental health within the research interview itself as *'illuminating'* and *'crystallising things'* for them. It is possible that the one hour interview had provided an opportunity for them to reflect on this topic. Boyd & Fayles suggest that conversations can be a "process of creating and clarifying the meanings of experiences in terms of self in relation to both self and world. The outcome of this process is changed conceptual perspectives" (1983, p.101). It seems that there are few forums for local church leaders to have such conversations at present.

The leaders in the current research felt suspicious of mental health services, thinking that psychiatrists have severe doubts about faith communities. Only one leader said he/she would never refer to services. However, many more held reservations about what would happen if they did. A further barrier to involving services is the concern leaders had regarding congregant's faith being undermined if they attended secular mental health services. One leader said:

*"We would never tell someone 'don't go and talk to them unless they are Christian' ... but if that person was saying 'part of your problem is God, forget religion' then maybe I would say, 'hang on a minute that is not good advice'."*

This is consistent with church leaders in the journals reviewed by Oppenheimer and Weaver (2004). Research suggests that some of this suspicion is corroborated by clinicians. Smiley (2000) interviewed a sample of non-religious British clinical psychologists about their work with religious clients. Interviewees in Smiley's research acknowledged that a difference between their own and clients' religious beliefs could affect the therapeutic relationship. All interviewees openly expressed their view that clients' religious beliefs were "incorrect representations of reality"

(p.5), whilst they also reported feeling that they took a neutral position towards religion. Approaches to disagreement with clients' beliefs included 'ignoring the issue' and 'challenging beliefs'. Furthermore, most said that they did not include a religious client's faith in the therapeutic process. Thus, church leader's suspicions about working with mental health professionals may be realistic.

However, some of the suspicion may be inflated by leaders having a lack of understanding of mental health services. In relation to 'treatment' provided by mental health services, the leaders seemed aware only of the medical model options, such as medication, which some church leaders can find problematic. This is perhaps unsurprising as Burke (1993) found that the general public accepted the medical model of mental illness nearly 90% of the time, much more so than clinical psychologists. Psychological models, using context and creating space for personal meaning, were not recognised by church leaders in this research, who also struggled to identify what a psychologist does. Most leaders perceived the decision regarding support available as either a spiritual (church or Christian counsellors) or medical model (G.P., psychiatrist) being the only available options. For example, one leader, when asked *'would you suggest an individual attends mental health services?'* responded, *'I do not agree with antidepressants'*. It is possible that misunderstandings regarding the mental health services could be leading church leaders to make decisions against referrals or recommending mental health services based on inaccurate information.

The church leaders in the current study perceived dichotomous world views between the church and the NHS, representing secular and spiritual beliefs respectively. For some leaders this was incompatible. One area where the perceived difference between the two worldviews was most apparent to leaders was in respect to language:

Ben: *"I could speak to you [the researcher] on a different level because you [as a Christian] understand my terminology and you understand my philosophy and you can understand why I am doing what I am doing"...*

The way in which the leaders described 'them' (services) and 'us' (the church) is resonant with Social Identity Theory (Tajfel & Turner, 1986). This has been tested in a wide range of fields and settings such as stereotyping, language use and dealing with social change. It holds that social identity is "the knowledge that [one] belongs to certain social groups together with some emotional and value significance of...the group membership" (Tajfel, 1972, pp.31 as cited in Greenfield *et al.*, 2007). The theory addresses how perceptions of group identity can lead to certain inter-group and intra-group behaviours and attitudes.

There was a presumption that the researcher (as a Christian) would understand the church leader's language and a presumption that others would not. At times during the research process the researcher reflected on how rich in metaphor and Biblical imagery church leaders' language was which may indeed be difficult for researchers or clinicians who are not familiar with it to understand.

#### **4.2.4.1 Ideological uneasiness**

When interviewing church leaders about the cause of mental health difficulties Mathews (2008) thought that leaders felt the need to discuss both spiritual *and* psychological causes of mental health difficulties. This was in order to 'safeguard the sanctity of their unique religious perspectives, but at the same time appear sophisticated in a world where scientific rationality was held in high esteem" (p.297).

It was apparent in some of the church leaders' responses that the manner in which their beliefs, expectations and actions 'fit' together in the domain of supporting individuals with mental health difficulties could result in a feeling of uneasiness, especially if they encourage people to access mental health services. Their responses revealed a degree of dissonance:

*Ben: "It's a fine line you walk because you believe in faith and you believe in the power of the gospel to heal, which it does. But you also have to know that er that er God is not against medicine or medical professions"*

#### **4.2.4.2      *The belief that Christians should not get ill***

The majority of leaders discussed the belief maintained in some areas of Christian culture that 'Christians should not get ill'. There is a recognised role in religion of encouraging people to call on God for supernatural healing (Paloutzian, 1996). McGuire (1988) studied middle class suburban women involved in a healing group to monitor their responses when healing did not occur. It was found that human limitations were blamed, the problem being explained in terms of "not knowing how to accept healing" or by "not thanking the Lord every day."

Some leaders described this belief as a problem because of the manner in which it induces feelings of failure and guilt when people do get ill. In addition, some described it as ostracising some ill individuals. Although none of the leaders subscribed to this view themselves, they considered it to be partly to blame for maintaining mental health difficulties as a taboo issue in church circles. This belief may reflect some difficulties church leaders have with how to teach the Christian doctrine of healing, as there are biblical scriptures which suggest God heals people<sup>12</sup> and people who claim to have been healed (Elsdon-Drew, 1995). However, supernatural healing is far from a guarantee and in modern society, it is clear that there are also mental health services that can help. It seems that holding beliefs that God can heal, yet being aware of the need for mental health can create a tension for leaders. In this post-modern period church leaders may find themselves in a 'betwixt and between time' (Turner, 1983) encountering increasing numbers of people with mental health difficulties and wanting to embrace 'secular' solutions whilst 'safeguarding the sanctity of the religious perspective' (Mathews, 2009, p.297).

Lewis: *"So do I think it is alright to take anti-depressants? Yeah, I think that is fine, that is great. Can God heal people? Yes, as well. It's really difficult"*.

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<sup>12</sup>E.g. "Bless the Lord, O my soul, and forget not all His benefits: who forgives all your iniquities; who heals all your diseases ..." (Psalm 103:2)

"He heals the broken-hearted and binds up their wounds ... Great is our Lord ..." (Psalm 147:3)



However, despite the leaders' uneasiness about referring congregants to services, only one leader said that they would not refer. Some leaders do not overtly warn against going to medical professionals but may avoid discussing this option with congregants. This may communicate the idea that they do not fully support the use of such help:

*Clive: I don't want undermine any medical professional, so I don't. I don't talk to them [the congregant] about what the psychiatrist is saying. I just, if you like, speak the Word to them, the Bible, and encourage them and love them. There's been times, occasionally I've just cautioned them [to be careful when speaking to mental health professionals]*".

Congregants within Clive's church may be aware of an underlying uneasiness with respect to mental health services. Pattison (2000) suggested that pastoral carers need to develop awareness of their power when working with vulnerable individuals. The values church leaders communicated consciously and subconsciously through the pastoral relationship and the pulpit are important to consider.

Schlauch (2000) argued that the church needs to develop a pastoral model for leaders which allows theological and secular conversations to come together in pastoral care. He argued that there is a continuum of care in pastoral work. On one end, the care is based on theological or religious ideas, noting psychological ideas in passing. On the other end of the continuum is primacy of social science discourse, in the light of which theological ideas are reconstructed. He felt that the middle involves theological and secular ideas being used as equal partners. A change in culture like this is beyond the influence of individual church leaders and is likely to reside more at the level of theological and leadership training.

#### **4.3 SUMMARY**

The results of this research suggested that the leader's concept of mental health difficulties was a major influence in the way in which support was given. The church leaders described a breadth of long and short term support provided to individuals

with mental health difficulties. Influenced by the leader's desire to create a caring community reflecting Biblical values of love and acceptance, the support differs both in style and motivation from that which is offered by mental health services.

Church leader's varied on how much they perceived a need to access mental health services for congregants. The leader's perception of their competency to support the individual and whether they had positive prior experience of mental health services influenced this. The majority of leaders felt under-trained to support people with mental health difficulties and unsure what the mental health services could provide. The taboo around mental health within church meant that information and training relating to mental health difficulties had been lacking.

The willingness of leaders to recommend to secular mental health services also varied between leaders. Congregants may be overtly advised against using services, or more commonly, get a sense from the teaching or actions of the leader that secular services may not fit well with Christian faith. This may also be bolstered by the belief held by some that Christians should not get ill.

Consequently, a high number of individuals with mental health difficulties considered too complex to manage within church may be referred to Christian counsellors. Whether the Christian counsellors refer to mental health services remains to be explored

#### **4.4 IMPLICATIONS AND RECOMMENDATIONS**

##### ***4.4.1 Implications and recommendations for psychologists***

Respect for client values which differ from those of the professional offering help is a stated component of good practice for Psychologists (BPS/DCP, 1995). However, qualitative research has illustrated the way in which religious and spiritual experiences of service users can be pathologised, ignored or dismissed by many some working in mental health services (Nicholls, 2002, Turbott, 2004). This

literature review has highlighted how both trainee and qualified Clinical Psychologists receive little or no training on how to communicate with clients who hold religious beliefs, despite the number of people in the population who describe themselves as religious. Furthermore, Koenig *et al.* (2001) suggested that many health professionals are unaware of the large body of research regarding spirituality as a major resource enabling people to cope better with their mental health problems. This may suggest that some of the concerns of the church leaders regarding referring congregants to mental health services could be valid, although that is beyond the scope of this research.

To remedy this, a psychologist may find it helpful to include one or two pertinent questions during the assessment phase of therapy regarding whether a client holds religious or spiritual beliefs which are important to them. The Royal College of Psychiatry has published brief guidance on how to do this in a user-friendly way which suggests sensitive ways of exploring this issue (see Culliford & Johnson, 2003, Appendix 15).

Some clinicians may feel comfortable enquiring about spirituality and religion during therapy. For others, the idea has produced heated debates (Dein *et al.* 2010). Some psychiatrists have expressed concern that professional boundaries could be breached if spirituality is discussed; they feared that it may indicate a lack of respect for individuals who reject transcendence themselves, or risk causing harm to patients with religious delusions. Moreover, Cook (2011) raised professional, therapeutic and ethical issues with discussing spirituality such as those arising from the question of what should be done if it seems therapeutically important for a client to discuss spiritual issues, but the psychiatrist feels that such issues are outside his/her competencies? He also poses the question of what should be done if the client wishes to discuss a spiritual tradition which is shared by the psychiatrist, who fears the discussion in case it would be taken as proselytising? Hopefully this recent debate will result in guidelines on how to manage these dynamics.

It is likely that most psychologists would want further training in this area before broaching spirituality and religion in their assessment. For example, research on

therapy outcomes among diverse populations has emphasised the need for therapists to speak the 'same language' as clients (Plante, 1999). As numerous church leaders in the current research said, 'the language' used by Christians can be difficult to comprehend. Without some training, if a client uses biblical phrases or metaphors they may be misunderstood by the clinician. Crossley & Salter (2005) found that clinical psychologists faced an obstacle of inadequate vocabulary in attempting to discuss spirituality; further training may facilitate the development of appropriate clinical language. Nonetheless, research is also required on the best manner to present the training, as Golsworthy & Coye (2001) found that the psychologists' personal orientations towards religion and spirituality, rather than clinical training, are the primary determinants of their clinical approach to issues of spirituality and religion.

#### ***4.4.2 Implications and recommendations for services***

There are several key recommendations arising. The current research does not address the issue of whether the barriers discussed do prevent people with religious beliefs from attending adult mental health services with or without their church leaders support. An audit of this would be useful to see if the issues raised in this research are significant enough to impact the care pathway for this group.

Secondly, several church leaders report visiting congregants in inpatient settings. Therefore, those working in inpatient mental health services should ask service users about their spiritual and religious needs upon entry to the service. The WAG spiritual care policy (2010) suggests that a protocol should be in place in inpatient settings to refer religious clients to faith communities on discharge. Whilst so little is known about the extent to which faith leaders are supportive of psychological intervention, this needs to be done sensitively, on an individual basis, and with the needs of the client being kept central.

Thirdly, it is **essential** that connections between mental health services and faith communities are established. In the current research the only connection to mental health services the majority of leaders had was via GPs within the church, and not all

leaders had that resource. Likewise, Copsey (2001) recognised that many faith communities of a London Borough also had no relationship to the local mental health services. He visited the leaders of all the faith communities in the area, including 13 different Muslim communities, and ascertained how the mental health service could be more useful to them. The results of his research formed the basis for the mental health trust's religious and spiritual services. It is possible for such connections to be made, but for this to happen service development needs to occur. Perhaps, following this study, as Foskett (2004a) also recommended, a person needs to be employed to fulfil this role in the community.

Fourthly, the Chaplain interviewed in this research said that a Chaplain is the best person for a psychologist to contact if they have questions about the interaction between mental health difficulties and religion. Mental health chaplains stand both within denominations and outside of them, whilst also understanding mental health difficulties. In addition, the Church in Wales has a mental health coordinator who can be contacted through the Bishop's office. This information is not currently easily accessible to psychologists or psychiatrists but could easily be made more available, perhaps through clinical psychology training courses.

Mental health services could also provide training for church leaders. From the church's perspective, a survey of UK church leaders by Premier radio (2008) found that 58% would like to be able to offer more support for individuals with mental health difficulties.

Eight of the leaders in the current research thought that the NHS could offer training and said that they would be likely to attend. They thought the following components would need to be incorporated in the training:

- An understanding of the Christian perspective
- Explanation of who does what in mental health services and how it fits together
- Strategies which could be easily applied in church settings
- Low cost
- One day in length

One cost effective way of providing training would be by running Mental Health First Aid courses, which are a nationwide initiative and endorsed by the Department of Health (MFA, 2009). A collaboration between social services and churches working with people who are homeless in Cardiff runs this training for involved church leaders and volunteers. A similar model could be employed for individuals in the community supporting individuals with mental health difficulties.

A further issue is the need for dialogue between professions. Psychologists need to promote their skills to faith communities, as many church leaders do not know what psychologists do, and do not appreciate the fact that there is an alternative to a medical model approach within the NHS. Similarly, one leader expressed a need for church leaders to be able to explain to mental health professionals that church can be a positive experience for people with mental health difficulties.

When psychological services moved into the community it was hoped to improve multi-agency collaboration, however churches are rarely included in collaboration around mental health care provision. For example, two leaders in the current research wondered why they were never contacted in respect to case conferences. Tom wondered why:

*“If they [mental health services] have a case conference and bring in certain people ... why don't they ask 'is this woman part of the church community? Has that church leader had any input into the family? Can we draw on them? Let's get together for an hour, let's see and find out'. But more and more within the health service, us guys are being excluded, particularly in this health authority”.*

In America, collaboration between services and faith community has occurred through bidirectional consultation and referrals (Edwards, 1999); psychological evaluations with clergy applicants (Plante, 1999) and developing models to help clergy and clinicians demarcate their boundaries (e.g. Milstein *et al.*, 2010). In the UK signs of interaction are in its early stages and consist of the creation of special interest groups (Gilbert, 2006), the development of government policy regarding

spirituality and mental health (e.g. WAG, 2010) and increasing the prominence of chaplains. As Oppenheimer and Weaver (2004) suggested, in order for collaboration to further develop, the awareness of mental health professionals about the role community clergy play in the mental health arena needs to develop.

In February 2011 a conference, “Increasing Access to Psychological Therapy in Wales” was held in Cardiff. It was attended by local mental health professionals and hosted by the National Leadership and Innovation Agency for Healthcare and the British Psychological Society. The need to reach disenfranchised groups who do not easily access therapy such as the elderly, or those from different cultural backgrounds was discussed. When services such as Increasing Access to Psychological Therapy (IAPT) are being developed, church leaders could be recognised as professionals within the community involved in maintaining good mental health and flagging up problems at the earliest, or most timely opportunity. Church leaders’ perspectives could feed into the IAPT decision-making process for Wales (Seager, personal communication, 9 February 2011).

#### **4.4.3 Implications and recommendations for church leaders**

This research raises two main implications for church leaders. One is strategic, the other theologic. Strategically church leaders could take a greater role in caring for those with mental health difficulties. Leavey *et al* (2007) thought that church leader training should highlight the major function and role of caring for those with mental health difficulties but questioned whether clergy would be ready for a more formalised addition to their role. Many clergy provide pastoral care for people with mental health difficulties but could be reluctant to move away from ‘spiritual guidance’, their core business, towards a more secular enterprise (Leavey & King, 2007). Some church leaders consider this diversification as corrosive to their primary role as a spiritual leader, and as further evidence of the secularisation of religious organisations (Pattison, 2000). It seems that this debate needs to be raised with national leadership teams and training bodies.

Theologically, church leaders could usefully present the Bible in a way that emphasises God’s grace and forgiveness alongside promoting Biblical standards of

living. This might ameliorate some congregant's struggles with guilt. In the current research Church leaders demonstrated an awareness of the negative impact on emotional wellbeing that failing to reach high expectations, or even simply experiencing mental health difficulties within a congregation could have. It may be useful, as some leaders mentioned, to promote honesty regarding personal struggles and encourage Biblical understandings of the self, God, and how He relates to people, especially in relation to those facing personal difficulties. Finally, the endorsement of mental health services by Christian communities may facilitate appropriate help being sought by Christians in distress.

#### **4.5 METHODOLOGICAL CRITIQUE**

The qualitative methodology used in this research was an appropriate way in which to meet the research aims. It enabled the researcher to gain rich, in-depth accounts of participants' experiences of supporting individuals with mental health difficulties. Feedback from those who took part in the research was very positive and some leaders have expressed a keenness to collaborate in the future. Such is the dearth of research and lack of dissemination in the area that some national church leaders have heard about this research and expressed interest in discussing the findings. Several of the researcher's cohort of trainee psychologists have expressed a training need in their own clinical development, relating to clients with religious beliefs, and have also said that they would like the researcher to present her findings to the group.

Throughout the study, the researcher aimed to maintain a high level of quality in the research by adhering to the guidelines proposed by Elliot *et al.* (1999). The following paragraphs explain how these guidelines were met.

The researcher aimed to own her own perspective by both stating it (see 2.6) and keeping a research journal where she reported her thoughts and monitored her responses to the developments (see Appendix 12) to help her recognise her values, interests and assumptions.



The sample was situated, describing the participant's life circumstances to aid the reader in judging the situations in which the findings might be relevant. Throughout the report, examples of data are given to illustrate the fit between the data and the researcher's understanding of them.

In line with the grounded theory approach to the methodology, additional questions were added to the interview schedule as different topics arose in interview. Also, after the first four interviews, a brief analysis was conducted in order to influence the direction of the remaining interviews and inform theoretical sampling.

The credibility of the categories and accounts collected was ascertained in several ways. Respondent validation was achieved by sending a brief copy of the results to all of the participants in order to check their understanding of them and to confirm whether the results were in line with their experience. Their responses are shown in the results chapter (2.11.2).

In addition, inter-rater reliability was conducted on a randomly selected sample of categories (see 2.11.3). The draft of this research report was also read by two supervisors and a non-psychologist to ensure clarity and coherence. 'Theoretical sampling' was also utilised to test the emerging categories by presenting them to a strategist and a Chaplain involved in mental healthcare.

Nonetheless and despite these rigorous efforts, a number of limitations are inherent in the work. Inevitably, this research provided a broad overview of a complex subject area. Consequently, some subcategories may not have reached theoretical saturation, defined by Strauss & Corbin, 1998, (p.143) as "the point in category development at which no new properties, dimensions, or relationships emerge".

In order to try and retain a sample homogenous in beliefs a decision was made early on in the process to restrict the sample to only protestant church leaders. However, in retrospect, it may have been useful if Roman Catholic Priests had been invited to take part, as this may have added to the richness of the data. In addition, although all of the protestant mainstream Christian church leaders were invited to take part in

the research, the final sample included a large number of non-denominational leaders which may not be generalisable to church leaders in South Wales. (The researcher was unable to find data which would cast light on what proportion of churches are non-denominational in south Wales).

Furthermore, recruitment in this manner may involve an inherent sample bias, as those who did respond and were willing to engage in discourse about mental health difficulties may be very different from those church leaders who did not respond. Only one female leader took part, so it is possible there could be a 'male as norm' effect. However, data regarding how many female church leaders there are in South Wales could not be found and it could be that one female church leader in ten is representative of South Wales (no data could be found to confirm this).

Finally, discourse regarding race, which has been central in some similar research (Payne, 2009), was absent in this study. One reason for this may have been that although one leader described herself as being of dual heritage, the 11 others were white and race was not mentioned a prominent factor for them or their congregants.

In addition, a social desirability bias may have influenced some of the church leader's responses. The researcher reassured the participants that there were no correct or 'desirable' answers. However, some of the responses suggest an awareness of elements of the researchers' identity as a female, Christian psychologist. This may well have impacted the findings. Future research could elucidate this.

#### **4.5.1 Personal and epistemological reflexivity (Willig, 2008)**

The researcher was committed to reflecting on how her values and experiences shaped the research. Sharing similar beliefs to some of the church leaders did enhance theoretical sensitivity (Strauss & Corbin, 1990) affording a degree of insight and understanding. However, it also meant the researcher was at risk of assuming that she knew what the church leaders meant when they used terms which are

commonly used in Christian culture. As much as possible the researcher asked the church leaders to clarify what they meant to avoid assumption.

The research process challenged the researcher's assumptions and perspective regarding the causes, consequences and healing of mental health difficulties. Through the process the researcher considered the benefits and disadvantages of the professionalisation of spiritual and mental healthcare. She also reflected on her thoughts regarding how much training is necessary to offer both. Often she felt a great deal of respect and admiration for the support offered by church leaders who did not benefit from the training or supervision given to clinicians but faced some similar situations.

The researcher may have achieved personal reflexivity to a greater extent than epistemological reflexivity. In an attempt to stay grounded in the data, at times the researcher may have erred on being descriptive more than analytical during the analysis phase. In order to be exploratory and not to prejudge the research issue, or impose the researcher's own constructions, the questions were kept deliberately broad. Consequently, the data which emerged covered a broad range of topics such as the beliefs and actions of the church leader, the congregant and the organisational structure of the church and the NHS. This breadth was challenging to manage, especially as a first experience of grounded theory analysis. As a consequence, in creating categories and aiming to contain the breadth, some 'construction' may have been applied to the data. Nonetheless, adopting a critical realist position recognises that 'scientific theories cannot be isomorphic to their real referents because they contain simplifications and idealisations' (Bunge, 1993, p.25).

A number of alternative designs could have been levied to research this question which in turn may have reduced the breadth of findings and increased the richness in the resultant categories. The church leaders could have discussed several vignettes regarding what they would do when faced with certain situations for example, a congregant who says that God is telling them to do something which seems unusual. However, this was originally rejected as a design because it was felt it might have led to a perceived need to produce the 'right' answer'.

Several researchers have focussed interviews with church leaders around one type of mental health difficulty. For example, Trice & Bjorck (2006) and Kramer (2007) both focussed on depression. Depression would have been an interesting choice for the current study, as most leaders knew of congregants who seemed to have experienced it. In addition, the question of whether church leaders felt comfortable supporting individuals taking antidepressants was raised and encapsulates the ideological uneasiness category described in this research. However, this approach may not have accessed information about the severity of distress some congregants are in, the crisis support offered by the church and behaviour in other severe circumstances.

Nonetheless, this research area is at an early stage. Consequently, exploratory methods were necessary. Thus, the research process selected was appropriate given the original question asked.

#### **4.6 RECOMENDATIONS FOR FUTURE RESEARCH**

The current research highlighted several possible areas for future investigation:

- 1) It would be useful to undertake research using the same methodology with leaders from different religious communities, by researchers with in-depth understanding of each community. This could then feed into a multi-faith approach to increasing conversation between faith communities and mental health services.
- 2) The current study suggested that some of the difficulties church leaders faced in supporting individuals came from a lack of training in the area. National leaders of Bible and Theological colleges could be interviewed to see how future leaders are being equipped to support individuals with mental health difficulties.

- 3) Following this exploratory research, future research could use the same methodology but focus on another question such as what it means to a church leader when an individual does not recover from mental health difficulties, or how long-term support of congregants impacts on the well being of the church leader.
- 4) It was apparent from this research that a large number of church leaders refer congregants to Christian counsellors. It would be interesting to interview Christian counsellors to explore their experiences of supporting people with mental health difficulties, and if and when, they refer to mental health services. This may cast further light on the care pathway of congregants.
- 5) A UK wide study of churches with a large number of congregants with mental health difficulties, and/or a developed structure for supporting them could be conducted. This may indicate 'what works' in church when supporting people with mental health difficulties.
- 6) The effects of a training package, such as the mental first aid course, on church leader's attitude towards mental health difficulties could be conducted. This would usefully be evaluated in the context of faith-specific language and a bio-psycho-social-spiritual understanding of personhood.
- 7) This research did not allow much insight into the content of the pastoral counselling which many of the church leaders undertook. Some leaders mentioned focussing on 'speaking right', or developing a sense of biblical identity. Examining what the leaders base their pastoral sessions on, what they are hoping to change and how they judge whether it is successful or not would be another way of looking at how church leaders provide support. This may also afford more insight into the leader's concept of mental health difficulties and how they differentiate themselves from mental health services.
- 8) Finally, given that many aspects of religion and spirituality are concerned with care, rather than cure, further research could explore the impact and effectiveness of the 'healing' dimensions of different spiritual activities.

#### **4.7 CONCLUSION**

This research aimed to explore how church leaders support congregants with mental health difficulties. It has shown how church leaders provide a unique relationship for congregants offering faith, social support and hope. It is been apparent throughout this research that psychology and the Christian faith are very different fields, each holding unique vocabularies, anthropologies, and worldviews (McMinn, 2006). However, both see themselves as agents of care and healing and share the goal of being compassionate toward those they serve (Shifrin, 1998). If dialogue continues it is possible that both could recognise each other's skills and the NHS, the church, and the congregants could benefit.

## REFERENCES

- Allport, G. W. & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, 30, 405-422.
- Ameling, A. (2000). Prayer: An ancient healing practice becomes new again. *Holistic Nursing Practice*, 14, 40-48.
- Andrews, B., Qian, M.Y. & Valentine, J.D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology*, 41, 29-42.
- Ano, G.G., & Vasconcelles, F.B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology*, 61, 4, 461-480.
- Asch, S.E. (1956). 'Studies of independence and conformity: A minority of one against a unanimous majority'. *Psychological Monographs*, 76, 9, 400-416.
- Baker, M. (2010). How do service-users experience their local faith community and their mental health staff team? A UK perspective. *Journal of Psychology and Christianity*, 29, 3, 240-251.
- Baker, M. & Wang, M. (2004). Examining connections between values and practice in religiously committed UK clinical psychologists. *Journal of Psychology and Theology*, 32, 2, 126-136.
- Barbour, R.S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal*, 5, 322, 1115-1117.
- Barker, M. (2000). *Psychology, Religion and Mental Health*. Edinburgh: Rutherford House.
- Barker, C, Pistrang, N, Shapiro, D.A., Shaw, I. (1990). Coping and help-seeking in the UK adult population. *British Journal of Clinical Psychology*, 29, 3, 271-285.
- Barrett, J.L., Richert, R.A. & Driesenga, A. (2001) God's belief versus mothers: The development of nonhuman agent concepts. *Child Development*, 72, 1, 50-65.
- Batson, C. D., Schoenrade, P. & Ventis, W. L. (1993). *Religion and the Individual*. Oxford, England: Oxford University Press.
- Beck, A.T. (1987). Cognitive models of depression. *Journal of Cognitive Psychotherapy*, 1, 5-37.
- Bendetto, R. (2008). *The New Westminster Dictionary of Church History: Volume One: The Early, Medieval and Reformation Eras*. Kentucky: John Knox Press.

- Benes, K.M., Walsh, J.M., McMinn, M.R., Dominguez, A.W. & Aikins, D.C. (2000). Psychology and the church: An exemplar of psychologist-clergy collaboration. *Professional Psychology: Research and Practice*, 31, 5, 515-520.
- Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology*, 48, 95-105.
- Bergin, A.E. (1983). Religiosity and mental health: A critical re-evaluation and meta-analysis. *Professional Psychology: Research and Practice*, 14, 170-184.
- Bhugra, D. (2002). Self-concept: Psychosis and attraction of new religious movements. *Mental Health, Religion and Culture*, 5, 239-252.
- Blumer, H. (1969). *Symbolic Interactionism*. Englewood Cliffs, NJ: Prentice Hall.
- Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice and scientific enquiry. *Annals of Family Medicine*, 2, 6, 576-582.
- Boyd, E. & Fales, A. (1983). Reflective Learning: The key to learning from experience. *Journal of Humanistic Psychology*, 23, 2, 99-117.
- Brierly, P. (2000). *Religious Trends, UK Christian Handbook*. Carlisle: Paternoster publishing.
- British Psychological Society/Division of Clinical Psychology (1995). *Professional Practice Guidelines*. Leicester: British Psychological Society.
- Buist-Bowman, M., A., Ormel, J., de Graff, R. & Vollebergh, W. A. M. (2004). Functioning after a major depressive episode: complete or incomplete recovery? *Journal of Affective Disorders*. 82, 1, 363-371.
- Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision*, 35, 3, 207-235.
- Burke, J. J. (1993). Attitudes toward mental "illness" among clinical psychologists, allied health professionals, and the general public (Doctoral dissertation, Saybrook Institute Graduate School and Research Center, 1993). *Dissertation Abstracts International*, 54 (9-B), 4963.
- Charmaz, K. (1990). 'Discovering' chronic illness: using grounded theory. *Social Science Methodology*, 30, 11, 1161-1172.



Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In J. Gubrium & J. Holstein (Eds.). *Handbook of Interview Research: Context and Method* (pp. 675-694). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing Grounded Theory*. Thousand Oaks, CA: Sage.

Church of England (1991). Community Care and Mental Health, General Synod miscellaneous paper, 386.

Cinnirella, M. & Loewenthal, K.M. (1999). Religious and ethnic group influences on beliefs about mental illness. *British Journal of Psychology*, 72, 505-254.

Collicutt, J. (2011). Psychology, religion and spirituality. *The Psychologist*, 24, 4, 250-251.

Cook, C.H, Powell, A., Sims, A., Eagger, S. (2011). Spirituality and secularity: professional boundaries in psychiatry. *Mental Health, Religion & Culture*, 14, 1, 35 - 42.

Copsey, N. (2001). *Forward in Faith*. London: The Sainsbury Centre for Mental Health. Retrieved on 24 November from [www.centreformentalhealth.org.uk/pdfs/scmh\\_forward\\_in\\_faith.pdf](http://www.centreformentalhealth.org.uk/pdfs/scmh_forward_in_faith.pdf).

Corbin, J. & Strauss, A. (2008). *Basics of qualitative research* ( 3<sup>rd</sup> edn). California: Sage Publications Inc.

Cornah, D., (2006). *The Impact of Spirituality on Mental Health. A Review of the Literature*. London: Mental Health Foundation.

Crossley, J.P. & Salter, D.P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 295-313.

Culliford, L. (2011). 'Beware! Paradigm shift under way'. *Mental Health, Religion & Culture*, 14, 1, 43- 51.

Culliford, L., & Johnson, S. (2001). '*Healing from Within: A Guide for Assessing the Religious and Spiritual Aspects of People's Lives*'. Retrieved 4 January 2011 from [www.rcpsych.ac.uk/pdf/CullifordJohnsonHealing.pdf](http://www.rcpsych.ac.uk/pdf/CullifordJohnsonHealing.pdf).

Cutland, T. (2000). *Intrinsic Christianity, Psychological Distress and Help-Seeking*. Unpublished doctoral thesis: University of Leeds.

Dein, S., Cook, C.C.H., Powell, A., & Eagger, S. (2010). Religion, spirituality and mental health. *The Psychiatrist*, 34, 63-64.

- Denzin, N.K., & Lincoln, Y.S. (1998). *Strategies of Qualitative Inquiry*. Sage: California.
- Dew, R.E., Daniel, S.S., Armstrong, T.D., Goldston, D.B., Triplett, M.F., & Koenig, H.G. (2008). Religion/spirituality and adolescent psychiatric symptoms: A review. *Child Psychiatry and Human Development*, 39, 4, 381–398.
- Diocese of Oxford (1996). Code of Ministerial Practice. Oxford: Oxford Diocese Office of Communications. In G., Lynch (Ed.) (2001) *Pastoral Care & Counselling*. London: SAGE publications.
- Dittes, J. E. (1969). Psychology of religion. In A. Lindzey and E. Aronson (Eds). *The Handbook of Social Psychology*, 5, pp.602-659. Reading, MA: Addison Wesley.
- Ditto, P.H., & Lopez, D.F. (1990). Motivated scepticism: Use of differential criteria for preferred and non-preferred conclusions. *Journal of Personality and Social Psychology*, 63, 568-584.
- Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology*, 48, 400-419.
- Dubay, T. (1977). *A Biblical Theology of Discernment*. San Francisco: Ignatius Press.
- Edwards, L.C., Lim, B.R.K., McMinn, M. & Dominguez, A.W. (1999). Examples of collaboration between psychologists and clergy. *Professional Psychology: Research and Practice*, 30, 6, 547-551.
- Elliot, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Elsdon-Drew, M. (1995). *The God Who Changes Lives*. London: HTB publications.
- Evangelical Alliance (2010). *21st Century Evangelicals: A snapshot of the beliefs and habits of evangelical Christians in the UK*. Retrieved on 8 April 2011 from [www.eauk.org/snapshot/read.cfm](http://www.eauk.org/snapshot/read.cfm).
- Eysenck, H.J. (1975). Structure of social attitudes. *British Journal of Social and Clinical Psychology*, 14, 323-333.
- Fabricatore, A. N., Handal, P.J., Rubio, D.M., & Gilner, F.H. (2004). Stress, religion, and mental health: Religious coping in mediating and moderating roles. *International Journal for the Psychology of Religion*, 14, 2, 91-108.

Fallott, R. (2007). Spirituality and religion in recovery: Some current issues. *Psychosocial Rehabilitation Journal*, 30, 4, 261-270. Retrieved on 12 February 2011 from [www.professionalchaplains.org/uploadedFiles/pdf/T2.01%20Handout%20B%20Aist,%20Clark.pdf](http://www.professionalchaplains.org/uploadedFiles/pdf/T2.01%20Handout%20B%20Aist,%20Clark.pdf).

Faulkner, A. (1997). *Knowing Our Own Minds*. London: Mental Health Foundation.

Faulkner, A. & Layzell, S. (2000). *Strategies for Living*. London: Mental Health Foundation.

Fiala, E., Bjorck, J., & Gorsuch, R. (2002). The religious support scale: Construction, validation and cross-validation. *American Journal of Community Psychology*, 30, 761–786.

Foskett, J. (2001). Soul space: the pastoral care of people with major health problems. *International Review of Psychiatry*, 13, 101–109.

Foskett, J. (2001b). 'Can pastoral counselling recover its roots in madness?' *British Journal of Guidance & Counselling*, 29,4, 403-413.

Foskett, J., Marriott J. & Wilson-Rudd, F. (2004a). Mental health, religion and spirituality: Attitudes, experience and expertise among mental health professionals and religious leaders in Somerset. *Mental Health, Religion & Culture*, 7, 1, 5-22.

Foskett, J., A. Roberts, R. Mathews, L. Macmin, P. Cracknell, & Nicholls, V. (2004b). From research to practice: The first tentative steps. *Mental Health, Religion & Culture*, 7, 1, 41-58.

Francis, L. J. (1993). The dual nature of the Eysenckian neuroticism scales: A question of sex differences? *Personality and Individual Differences*, 15, 43-59.

Francis, L. J. (1997). The psychology of gender differences in religion: A review of empirical research. *Religion*, 27, 81-96.

Freud, S. (1959) *Civilisation and its discontents*. London: Hogarth.

Gieryn, T. F. (1999). *Cultural Boundaries of Science: Credibility on the Line*. Chicago: University of Chicago Press.

Gilbert, P. (2006). *Breathing Space*. Retrieved on 22 April 2011 from <http://www.communitycare.co.uk/articles/article.aspx?liArticleID=52421>.

Glaser, B. (1978). *Theoretical Sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A.L. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research*. Chicago: Aldine.

Goldstein, E., Eisenburg, D., Gollust, S.E. (2008). Perceived Stigma and Mental Health Care Seeking. *Psychiatric Services*, 59, 4, 392-399.

Golsworthy, R. & Coyle, A. (1999). Spiritual beliefs and the search for meaning among older adults following partner loss. *Mortality*, 14, 21–40.

Goulding, C. (1999). *Grounded Theory: Some Reflections on Paradigm, Procedures and Misconceptions*. Working Paper Series. Wolverhampton Business School Management Research Centre.

Gray, A.J. (2001). Attitudes of the public to mental health: A church congregation. *Mental Health, Religion & Culture*, 4,1, 71-79.

Green, D., Galvin, H. & Horne, B. (1998). The impact of infertility on young male cancer survivors: A qualitative investigation. *Poster presented at the International Conference on Long Term Complications of Treatment of Children and Adolescents for Cancer, Niagra-on- the-Lake, Ontario, Canada, 19-20 June*.

Greenfield, E.A & Marks, N.F. (2007). Religious Social Identity as an Explanatory Factor for Associations between More Frequent Formal Religious Participation and Psychological Well-Being. *International Journal of the Psychology of Religion*, 17, 3, 245-259.

Hackney, C., & Sanders, G. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, 42,1, 43-55.

Harrison, M.O., Koenig, H.G., Hays, J.C., Eme-Akwari, A.G., & Pargament, K.I. (2001). The epidemiology of religious coping: A review of recent literature. *International Review of Psychiatry*, 13, 86-93.

Hartog, K. & Gow, K.M. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion & Culture*, 8, 4, 263–276.

Hill, P. C. & Pargament, K., I. (2003). Advances in the conceptualization and measurement of religion and spirituality. Implications for physical and mental health research. *American Psychologist*, 58,1, 64-74.

Health Education Authority (1997). *Mental Health Promotion: A Quality Framework*. London: HEA. Retrieved 15 March from [www.library.nhs.uk/mentalhealth/viewresource.aspx?resid=105867](http://www.library.nhs.uk/mentalhealth/viewresource.aspx?resid=105867)

Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: Wiley.

Henwood, K.L. & Pidgeon, N.F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology*, 83, 1, 97-112.

- Hood, R.W., Jr., (1992) 'Sin and guilt in faith traditions: Issues for self esteem.' In J. Schumaker (Ed.). *Religion and Mental Health*, Oxford: Oxford University Press.
- Hook, J.N., Everett, L., Worthington, J., Davis, D.E., Jennings, D.J. & Gartner, A.L. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*, 66, 1, 46-72.
- Jensen, L.A. (2009). Conceptions of God and the devil across the lifespan: A cultural-developmental study of religious liberals and conservatives. *Journal for the Scientific Study of Religion*, 48, 1, 121-145.
- Jones, R. (1995). Editorial. *British Medical Journal*, 7, 311-312.
- Jones, S. L. & Butman, R.E. (1991). *Modern Psychotherapies*. Illinois: Inter Varsity Press.
- Jones, S., Guy, A., Ormerod, J.A. (2003). A Q-methodological study of hearing voices: A preliminary exploration of voice hearers' understanding of their experiences. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 189-209.
- Kelsey, R. & Kelsey, K. (2010). *The keys of faith and hope: The keys to the kingdom of God*. Indiana: iuniverse.
- Kim, S., Jorgensen, R.S. & Thibodeau, R. (2011). Shame, Guilt, and Depressive Symptoms: A meta-analytic review. *Psychological Bulletin*, 137, 1, 68–96.
- King, M. & Dein, S. (1998). The spiritual variable in psychiatric research. *Psychological Medicine*, 28, 1259–1262.
- Kirby, S.E., Coleman, P.G. & Daley, D. (2004). Spirituality and well-being in frail and nonfrail older adults. *Journal of Gerontology, Series B*. 59, 3, 123-129.
- Kirkpatrick, L. A., Shillito, D. J. & Kellas, S. L. (1999). Loneliness, social support, and perceived relationships with God. *Journal of Social and Personal Relationships*, 16, 4, 513–522.
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry*. Berkeley, CA: University of California Press.
- Koenig, H.G., Cohen, H.J., Blazer, D.G. (1992). Religious coping and depression in elderly, hospitalized medically ill men. *American Journal of Psychiatry*, 149,12, 1693-1700.
- Koenig, H.G., Pargament, K.I. & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease*, 186,9, 513-521.

- Koenig, H.G., McCullough, M.E., & Larson D.B. (2001). *Handbook of Religion and Health*. NY: Oxford University Press.
- Kramer, T., Blevins, D., Miller, T.L., Phillips, M.M., Davis, V. & Burris, B. (2007). Ministers' perceptions of depression: A model to understand and improve care. *Journal of Religion and Health*, 46, 1, 123-139.
- Lamont, M., & Molnar, V. (2002). The study of boundaries in the social sciences. *Annual Review of Sociology*, 28, 167-195.
- Lampropoulos, G.K. & Spengler, P.M. (2005). Helping and change without traditional therapy: Commonalities and opportunities. *Counselling Psychology Quarterly*, 18, 1, 47-59.
- Lazarus, R. S. & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.
- Leavey, G. (2008). U.K. clergy and people in mental distress: community and patterns of pastoral care. *Transcultural Psychiatry*, 45,1, 79-104.
- Leavey, G. (2010). The appreciation of the spiritual in mental illness: a qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry*, 47, 4, 571-590.
- Leavey, G. & King, M. (2007). The devil is in the detail: partnerships between psychiatry and faith-based organisations. *British Journal of Psychiatry*, 191, 97-98.
- Lindridge, A. (2007). *Keeping the faith: Spirituality and Recovery from Mental Health Problems*. London: Mental Health Foundation.
- Link, B.G. & Phelan, J.C. (2001) Conceptualising stigma. *Annual review of Sociology*, 4, 363-374.
- Lloyd-Williams, M., Cobb, M. & Taylor, F. (2006). How well trained are clergy in care of the dying patient and bereavement support? *Journal of Pain and Symptom Management*, 32, 1, 44-51.
- Lowenthal, K., M. (1995). *Mental health and religion*. London: Chapman & Hall.
- Lowenthal, K.M. (2000b). *A short introduction: The Psychology of Religion*. Oxford: One World Publications.
- Lowenthal, K.M. (2007). *Religion, Culture and mental health*. Cambridge: Cambridge University Press.

- Lowenthal, K.M. & Lewis, C.A. (2011). Mental health, religion and culture. *The Psychologist*, 256-259.
- Lynch, G. (Ed.) (2001) *Pastoral Care & Counselling*. London: SAGE publications.
- Lyons, E. & Coyle, A. (2007). *Analysing Qualitative Data in Psychology*. London: Sage.
- Lukten, P., Corveleyn, J. & Fontaine, J.R.J. (1998). The relationship between religiosity and mental health: Distinguishing between shame and guilt. *Mental Health, Religion and Culture*, 1, 165-184.
- Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.
- Masters, K. S. (2007). Prayer and health. In T. G. Plante & C. E. Thoresen (Eds.), *Spirit, science and health: How the Spiritual Mind Fuels the Body* (pp.11–24). Westport, CT: Praeger/Greenwood.
- Mathews, M. (2008). Explanatory models for mental illness endorsed by Christian clergymen: The development and use of an instrument in Singapore. *Mental Health, Religion & Culture*, 11, 3, 287–300.
- Maton, K. I. & Wells, E.A. (1995). Religion as a community resource for well-being: Prevention, healing, and empowerment pathways. *Journal of Social Issues*, 51, 177-193.
- Mayers, C., Leavey, G., Vallianatou, C. & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy*, 14, 317-327.
- McGuire, M.B. (1988) Ritual healing in suburban America. As cited in H.G Koenig, H.G (Eds.). *Handbook of Religion and Mental Health*. California: Academic Press.
- McKee, D. D., & Chappel, J. N. (1992). Spirituality and medical practice. *Journal of Family Practice*, 35, 201, 205–208.
- McLeod, J. (2003). *An Introduction to Counselling* (3<sup>rd</sup> edtn). Berkshire: Open University Press.
- McMinn, M.R., Chaddock, T.P., Edwards, L.C., Lim, B.R.K.B. & Cambell. C.D. (1998). Psychologists collaborating with clergy. *Professional Psychology and Practice*, 29, 6, 564-570.

McMinn, M.R., Ammons, J., McLaughlin, B.R., Williamson, C., Griffin, J.W. & Fitzsimmons, C. (2005). Collaborate with whom? Clergy responses to psychologist characteristics. In M.R., McMinn & A.W. Dominguez (Eds.). *Psychology and the Church*. New York: Nova Publishers.

McMinn, M.,R., Ruiz, J.N., Marx, D., Brooke Wright, J. & Gilbert, N.B. (2006). Professional Psychology and the Doctrines of Sin and Grace: Christian Leaders' Perspectives. *Professional Psychology: Research and practice*, 37, 3, 295-302.

McMinn, M.R., Vogel, M.J., & Heyne, L.K. (2010). A place for the church within professional psychology. *Journal of Psychology and Theology*, 38, 4, 267-274.

*Mental Health First Aid Course*. Retrieved 2 March, 2011 from [www.mhfaengland.org/about-us](http://www.mhfaengland.org/about-us)

Mills, J., Bonner, A., Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5, 1, 3. Retrieved 25 January 2011 from [http://ualberta.ca/~iiqm/backissues/5\\_1/pdf/mills.pdf](http://ualberta.ca/~iiqm/backissues/5_1/pdf/mills.pdf).

Milstein, G. (2003). Clergy and psychiatrists: Opportunities for expert dialogue. *Psychiatric Times*, 20,3. Retrieved 10 March 2011 from <http://find.galegroup.com.simsrad.net.ocs.mq.edu.au>

Milstein, G., Manierre, A. & Yali, A.M. (2010). Psychological care for persons of diverse religions: A collaborative continuum. *Professional Psychology: Research and Practice*, 41, 5, 371–381.

Mind (2011). *Wales Needs to Talk*. Retrieved 14 February 2011 from [www.mind.org.uk/mind\\_cymru/news/4464\\_wales\\_needs\\_to\\_talk](http://www.mind.org.uk/mind_cymru/news/4464_wales_needs_to_talk).

Mind (2011b). The history of mental health and community care- key dates. Retrieved 8 January 2011 from [www.mind.org.uk/help/research\\_and\\_policy/the\\_history\\_of\\_mental\\_health\\_and\\_community\\_care-key\\_dates](http://www.mind.org.uk/help/research_and_policy/the_history_of_mental_health_and_community_care-key_dates).

Miner, M. (2007). Changes in burnout in the first 12 months in ministry: Links with stress and orientation to ministry. *Mental Health, Religion & Culture*, 10, 1, 9-16.

Mitchell, J.,R. & Baker, M.,C. (2000). Religious commitment and the construal of sources of help for emotional problems. *British Journal of Medical Psychology*, 73, 289-301.

Moberg, D.O. (2002). Assessing and measuring spirituality: Confronting dilemmas of universal and particular evaluative criteria. *Journal of Adult Development*, 9, 1, 47-60.



- Mohr, S. & Huguelet, P. (2004). The relationship between schizophrenia and religion and its implications for care. *Swiss Medical Weekly*, 134, 369–376.
- Myers, D. G. & Diener, E. (1995). Who is happy? *Psychological Science*, 6, 10-19.
- National Institute for Mental Health in England (2003). *Inspiring Hope: Recognising the Importance of Spirituality in a whole person approach to Mental health*. NIMHE.
- Neeleman, J. & King, M. (1993). Psychiatrist' religious attitudes in relation to clinical practice. *Acta Psychiatrica Scandinavica*, 88, 420–424.
- Nicholls, V. (2002). *Taken Seriously: The Somerset Spirituality Project*. London: Mental Health Foundation.
- Nightingale, D., & Cromby, J. (1999). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Buckingham: Open University Press
- Nygren, A. (2007) Agape and Eros: excerpts. In Oord, J.,J. (Ed.).*The Altruism Reader: Selections from Writings on Love, Religion and Science*. West Conshohocken: Templeton Foundation Press.
- Office for National Statistics (2001). *KS07 Religion, Census 2001: Key Statistics for the Rural and Urban Area Classification*. Retrieved 16 March 2011 from [www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=8920&Pos=&ColRank=1&Rank=240](http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=8920&Pos=&ColRank=1&Rank=240)
- Okolo, R. (2010). *Speak the Word in the Face of Your Circumstances*. Indiana: Authorhouse.
- Oppenheimer, J.E., Flannelly, K.J. & Weaver, A.J. (2004). A comparative analysis of the psychological literature on collaboration between clergy and mental-health professionals-perspectives from secular and religious journals: 1970-1999. *Pastoral Psychology*, 53, 2, 153-162.
- Oxford Dictionary (2011). *Definition of 'denomination'*. Retrieved on 22 March 2011 from [www.oxforddictionaries.com/view/entry/m\\_en\\_gb0216470#m\\_en\\_gb0216470](http://www.oxforddictionaries.com/view/entry/m_en_gb0216470#m_en_gb0216470)
- Paloutzian, R.F. (1996). *Invitation to the Psychology of Religion*. (2<sup>nd</sup> Edtn.) Massachusetts: Allyn & Bacon.
- Pargament, K. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford Press.
- Pargament, K. I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J. & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion*, 27, 90-104.

- Pargament, K.I., Zinnbauer, B.J., Scott, A.B., Butter, E.M., Zerowin, J.L., & Stanik, P. (1998). Red flags and religious coping: Identifying some religious warning signs among people in crisis. *Journal of Clinical Psychology*, 54, 77–89.
- Pargament, K.I., Koenig, H.G., Perez, L.M. (2000). The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE. *Journal of Clinical Psychology*, 56, 4, 519-543.
- Pargament, K. & Maton, K. (2000). Religion in American life: A community psychology perspective. In J. Rappaport and E. Seidman (Eds.) *Handbook of Community Psychology* (pp. 495-521). New York: Kluwer Academic/Plenum Publishers.
- Pargament, K.I., & Saunders, S.M. (2007). *Introduction to the special issue on spirituality and psychotherapy*, 63,10, 903–907.
- Pattison, S. (1994). *Pastoral Care and Liberation Theology*. Cambridge: Cambridge University Press.
- Pattison, S. (2000). *A Critique of Pastoral Care*. (3<sup>rd</sup> Edtn.) Guilford: Biddles Ltd.
- Pattison, S., & Woodward, J. (2000) An introduction to pastoral and practical theology. In Woodward, J. & Pattison, S. (2000). *The Blackwell reader in Pastoral and Practical Theology*. Massachusetts: Blackwell Publishers Ltd.
- Payne, J.S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal*, 45, 355-365.
- Pfeifer S. & Waeltly, U. (1999). Anxiety, depression and religiosity – a controlled study. *Mental Health, Religion & Culture*, 1, 35-45.
- Plante, T.G. (1999). Collaborative relationship between professional psychology and the roman catholic church: A case example and suggested principles for success. *Professional Psychology: Research and Practice*, 30, 6, 541-546.
- Plante, T.G. (2008). What do the spiritual and religious traditions offer the practising psychologist? *Pastoral Psychology*. Retrieved on March 24, 2011 from [www.psychologytoday.com/files/attachments/34033/pp2article.pdf](http://www.psychologytoday.com/files/attachments/34033/pp2article.pdf)
- Plante, T. G., & Sharma, N. (2001). Religious faith and mental health outcomes. In T. G. Plante & A. C. Sherman (Eds.), *Faith and health: Psychological perspectives* (pp. 240–261). New York: Guilford.
- Premier Radio (2008). *Postal Survey of UK Church Leaders Regarding their Thoughts About Mental Health Services*. Unpublished dataset.
- Propst, L.R., Ostrom, R., Watkins, P., Dean, T. & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment

of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology*, 60, 94–103.

Re:Quest (2007). Diagram of different Christian Denominations. Retrieved on 22 March 2011 from [www.request.org.uk/main/churches/denominations/denominations01.htm](http://www.request.org.uk/main/churches/denominations/denominations01.htm)

Robinson, J. (2000). *Research Project on Mental Health and Black People in Britain*. London: Department of Health.

Roskes, E.J., Dixon, L. & Lehman, A. (1998). A survey of the views of trainees in psychiatry regarding religion. *Journal of Mental Health, Religion & Culture*, 1, 45–56.

Schlauch, C. (2000). Suffering, healing and reconstructing experiencing. In J., Woodward & S., Pattinson (Eds). *The Blackwell Reader in: Pastoral and Practical Theology*. Oxford: Blackwell Publishers Limited.

Scottish Executive Health Department (2002). *Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland*. Retrieved on March 12 from [www.sehd.scot.nhs.uk/mels/hdl2002\\_76.pdf](http://www.sehd.scot.nhs.uk/mels/hdl2002_76.pdf)

Scott W. R. (1998). *Organisations: Rational, Natural and Open Systems*. N J: Prentice Hall.

Seager, M. (2006) The Concept of “psychological safety” – A psychoanalytically-informed contribution towards safe, sound & supportive mental health services *Psychoanalytic Psychotherapy*, 20, 4, 266-280.

Seligman, M.E.P. (1991). *Learned Optimism*. New York: Random House.

Shiffrin, J. (1998). The faith community as a support for people with mental illness. *New Directions for Mental Health Services*, 80, 69-80.

Shuval J.T. & Mizrahi, N. (2004). Changing boundaries: Modes of coexistence of alternative and biomedicine. *Qualitative Health Research*, 14,5, 675-690.

Siddle, R., Haddock, G., Tarrier, N., & Faragher, E.B. (2002). The validation of a religiosity measure for individuals with Schizophrenia. *Mental Health Religion and Culture*, 5, 267-284.

Sims, A.C.P. (2006) What is mental disorder? In M.D. Beer & N.D. Pocock (Eds) *Mad, Bad or Sad? A Christian Approach to Antisocial Behaviour and Mental Disorder*. London: Christian Medical Fellowship.

Skinner, B.F. (1971) *Beyond freedom and dignity*. Reprinted in 2002. Indianapolis: Hackett publishing company.

- Smiley, T. (2001). *A Survey of the Attitudes And Practices Of Clinical Psychologists in South East England*. Unpublished doctoral thesis: University of Surrey.
- Spilka, B., Hood, R. W. & Gorsuch, R. L. (1985). *The Psychology of Religion : An Empirical Approach*. Englewood Cliffs, NJ: Prentice Hall.
- Stanford, M.S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, 10, 5, 445-449.
- Strauss, A.S. & Corbin, J. (1990). *Basics of Qualitative Research* (1<sup>st</sup> edition). Thousand Oaks, CA: Sage.
- Strauss, A.,S. & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Eds.) *Handbook of Qualitative Research* (pp.273-285). Thousand Oaks, CA: Sage.
- Strauss, A.S & Corbin, J, (1998). Grounded theory methodology an overview. In Denzin, N.K & Lincoln, Y.S. (Eds.) *Strategies of Qualitative Enquiry*. p.158-184, Sage publications, Thousand oaks, London (2<sup>nd</sup> edt).
- Swinton, J., (2001). *Spirituality and Mental Health Care: Rediscovering a Forgotten Dimension*. London: Jessica Kingsley Publishers.
- Tajfel, H. & Turner, J. C. (1986). The social identity theory of inter-group behavior. In S. Worchel and L. W. Austin (Eds.), *Psychology of Intergroup Relations*. Chigago: Nelson-Hall.
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and Guilt*. New York: Guilford Press.
- Tidyman, M. & Seymour, L. (2004). *Promoting Mental Health: A Resource for Spiritual and Pastoral Care*. Retrieved 14 January 2011 from [www.centreformentalhealth.org.uk/pdfs/mentality\\_parish\\_resource\\_march\\_2005.pdf](http://www.centreformentalhealth.org.uk/pdfs/mentality_parish_resource_march_2005.pdf)
- Trice, P.D.& Bjorck, J.P. (2006). Pentecostal perspectives on causes and cures of depression. *Professional Psychology: Research and Practice*, 37, 3, 283-294.
- Turbott, J. (2004). Religion, spirituality and psychiatry: Steps towards rapprochement. *Australasian Psychiatry*, 12, 2, 145-147.
- Turner, T. (2004). The history of deinstitutionalization and reinstitutionalization. *Psychiatry*, 3, 9, 1-4.

- Van de Creek, L., Pargament, K. I., Belavich, T., Cowell, B., & Friedel, L. (1999). The unique benefits of religious support during cardiac bypass surgery. *Journal of Pastoral Care*, 53, 19-29.
- Van Avermaet, E. (2001) Social influence in small groups. In M. Hewstone & W. Stroebe (Eds). *Introduction to Social Psychology* (3<sup>rd</sup> edtn).Oxford. Blackwell Publisher.
- Ventis, W. L. (1995). The relationships between religion and mental health. *Journal of Social Issues*, 51, 33–48.
- Verhagen, P., Van Praag, H.M., Lopez-Ibor, J.J., Cox, J. & Moussaoui, D. (2010). *Religion and Psychiatry: Beyond Boundaries*. Chichester: John Wiley and Sons.
- Waller, R. (2010). *Can We Find Friendly Churches?* Retrieved on 24 March 2011 from [www.mindandsoul.info/Publisher/Article.aspx?ID=180802](http://www.mindandsoul.info/Publisher/Article.aspx?ID=180802).
- Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ: Erlbaum.
- Weaver, A. (1992). Working with potentially dangerous persons: What clergy need to know. *Pastoral Psychology*, 40, 5, 313-323.
- Weaver, A.J., & Koenig, H.G.(1996). Elderly suicide, mental health professionals and the clergy: A need for clinical collaboration, training and research. *Death Studies*, 20, 495-508.
- Weaver, A., Flannnelly, L.T., Garbarino, J., Figley, C.R., & Flanelly, K.J. (2003). A systematic review of religion and spirituality in the Journal of Traumatic Stress: 1990-1999. *Mental Health, Religion and Culture*, 6, 215-228.
- Webster Dictionary (2011). Retrieved on 25 April 2011 from [www.merriam-webster.com/dictionary/system](http://www.merriam-webster.com/dictionary/system)
- Weitzman, E.A. (1994). Software and qualitative research. In Denzin, N.K., Lincoln, Y.S. *Handbook of Qualitative Research* (p.803-820). Thousand Oaks, CA; Sage publications, Inc. (2<sup>nd</sup> Edition).
- Welsh Assembly Government (2010). Standards for Spiritual Care Services in the NHS in Wales. Retrieved on June 24, 2010 from <http://wales.gov.uk/docs/dhss/publications/100525spiritualcaresstandardsen.pdf>
- Williams, B. & Healy, D. (2001). Perceptions of illness causation among new referrals to a community mental health team: Explanatory model or exploratory map? *Social Science and Medicine*, 53, 465-476.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Buckingham: Open University Press.

Willig, C. (2008). *Introducing Qualitative Research in Psychology*. Berkshire: Open University Press.

Wilson, W.P. (1997). Religion and psychoses. In H. Koenig (ed.). *Religion and Mental Health*. San Diego: Academic Press, 161-174.

Winnicott, D.W. (1958). *Collected Papers: Through Paediatrics to Psychoanalysis*. London: Tavistock.

World Council of Churches (1996). *Towards Sharing the One Faith. A Study Guide for Discussion Groups. Faith and Order Paper No. 173*. Retrieved on 23 march 2011 from [www.oikoumene.org/en/resources/documents/wcc-commissions/faith-and-order-commission/iii-apostolic-faith/towards-sharing-the-one-faith/towards-sharing-the-one-faith.html#c10582](http://www.oikoumene.org/en/resources/documents/wcc-commissions/faith-and-order-commission/iii-apostolic-faith/towards-sharing-the-one-faith/towards-sharing-the-one-faith.html#c10582)

Worthington, E.L., Hook, J.N., Davis, D.E. & McDaniel, M.A. (2011). Religion and spirituality. *Journal of Clinical Psychology: In Session*, 67, 2, 204-214.

Wright, F. (1980). *The Pastoral Nature of the Ministry*. Norwich: SCM press.

Yangarber-Hicks, N. (2004). Religious coping styles and recovery from serious mental illnesses. *Journal of Psychology & Theology*, 32,4 , 305-317.

## Appendix 1: The Nicene Creed

## **The Nicene Creed (Modern Wording)**

We believe in one God,  
the Father, the Almighty,  
maker of heaven and earth,  
of all that is, seen and unseen.

We believe in one Lord, Jesus Christ,  
the only son of God,  
eternally begotten of the Father,  
God from God, Light from Light,  
true God from true God,  
begotten, not made,  
of one being with the Father.  
Through him all things were made.  
For us and for our salvation  
he came down from heaven:  
by the power of the Holy Spirit  
he became incarnate from the Virgin Mary,  
and was made man.

For our sake he was crucified under Pontius Pilate;  
he suffered death and was buried.  
On the third day he rose again  
in accordance with the Scriptures;  
he ascended into heaven  
and is seated at the right hand of the Father.  
He will come again in glory  
to judge the living and the dead,  
and his kingdom will have no end.

We believe in the Holy Spirit, the Lord, the giver of life,  
who proceeds from the Father [and the Son].  
With the Father and the Son  
he is worshipped and glorified.  
He has spoken through the Prophets.  
We believe in one holy catholic and apostolic Church.  
We acknowledge one baptism for the forgiveness of sins.  
We look for the resurrection of the dead,  
and the life of the world to come. AMEN



Appendix 2: An overview of research examining the link between religiosity and psychopathology

## **AN OVERVIEW OF RESEARCH EXAMINING THE LINK BETWEEN RELIGIOSITY AND PSYCHOPATHOLOGY**

Lowenthal (2007) highlighted the fact that discourse regarding common Christian experiences such as communicating with an invisible God and 'hearing from God' can be difficult to understand. Foskett *et al.* (2004) surveyed 89 mental health professionals in the UK and found that 45% felt that religion could lead to mental ill health. Some mental health professionals wonder if religion, as a way of encouraging unusual beliefs and experiences, could in some cases contribute towards psychotic breakdown. It is known that emotional and psychological distress often does include religious content (Paloutzian, 1996). Whether religion is a cause of such phenomenon will be briefly explored. One of the areas of research which has been most illuminating regarding the type of religion which may lead to psychopathology is that regarding religious types or orientations.

### ***Intrinsic and extrinsic orientation***

As mentioned in the main text Allport & Ross (1967) originally suggested that there were two types of religious commitment. One was 'extrinsic' religion which was when an individual's religion is one "of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself" (p.400). This orientation of religious commitment has been found to be correlated with mental health difficulties. The other is 'intrinsic' religion which is regarded as a "meaning endowing framework in terms of which all of life is understood" (Donahue, 1985, p. 400). A positive connection has been found between this kind of religiosity and measures of mental health (Barker, 2000). Bateson *et al.* (1993) presented a third orientation to religion, as they felt that intrinsic and extrinsic religiousness did not cover the entirety of religious commitment. 'Quest' orientation leaves space for complexity, doubt and tentativeness as the person searches for meaning in life. It is a cognitive path relating to the way beliefs are formed and held.

Critics of the intrinsic/extrinsic dichotomy claim it is still not apparent whether this is a good measure of religious commitment, as it is unclear what psychological dimension it is tapping. It could be related to unmeasured elements such as motivation or cognition. Further testing, perhaps using non-western religious contexts could also make the distinction more valid (Paloutzian, 1996).

### ***Religion and anxiety***

Studies that have examined the relationship between religious beliefs, practice and anxiety have produced mixed results. Eysenck (1975) claimed that there was a relationship between religiosity and neuroticism (high anxiety). However, research concerned with the associations between aspects of religiosity and the Eysenckian dimensions of personality needs to take into account the established sex differences reported by these variables. According to which, females generally record higher scores than males on indices of religiosity (Francis, 1997) and on the neuroticism scales (Francis, 1993). Dittes (1969) found that religious people score higher than non-religious people on measures of anxiety and lower on self-esteem. Dittes (1969)

also found a difference between intrinsic and extrinsic religiosity, with those who score high on extrinsic measures being higher in anxiety. However, the link between anxiety, self-esteem and religiosity was based on correlational findings, so causation cannot be inferred.

More recently Pfeifer & Waelti (1999) measured religiosity and neuroticism in 44 service-users in Switzerland with affective, anxiety and personality disorders, and 45 healthy people as a control group. They did not find a significant correlation between religiosity and neuroticism, either in the service users, or in the control group. In addition, general life satisfaction was negatively correlated with neuroticism but positively with religiosity in the patient group.

### **Guilt**

Another factor in the proposed relationship between religiosity and psychopathology is the role of guilt. In particular, whether religion fosters feelings of guilt, shame and obsessionality due to the requirement to follow religious rules (Lowenthal, 2000). More recent theoretical and empirical advances demonstrate that shame and guilt are separate emotions with different implications for psychological adjustment (see Tangney & Dearing, 2002, for a review). Kim (2011) describes how feelings of shame occur when the entire self is the central focus of negative evaluation (e.g., "Look at what an awful person I am"), whereas feelings of guilt arise when specific behaviours represent the central focus of negative evaluation (e.g., "Look at the awful thing I did"). Kim (2011) explains, "Shame strikes at the core of a person's identity, and as a result, forces the individual to contemplate the possibility of a defective, unworthy, or damaged self. Guilt, on the other hand, leaves identity intact by implicating only specific behaviours" (p. 70).

In respect to religion, Hood (1992) concluded that there are mixed findings regarding guilt and religiosity. Some research finds higher levels of guilt in those who are religious, although findings are mixed (Hood, 1992). It is noteworthy that levels of shame are not higher in those who are religious (Luyten *et al*, 1998). It is shame (not guilt) that is thought to be linked to depression (Andrews *et al*, 2002, Lowenthal, 2007).

Luyten *et al* (1998) studied nearly 1000 Belgian adults to examine whether religiosity is associated with higher levels of guilt and whether this, in turn, is related to higher levels of anxiety. The study found that guilt may be higher in religious people but it is not an indicator of psychopathology, unlike shame, which was not found to be higher in those who are religious. Guilt was not associated with anxiety.

### **Religious content in psychotic illness**

Some researchers have suggested that religion may impact the presenting symptomatology of psychosis (Wilson, 1998). However, Lowenthal (2007) states that there is no strong evidence that religious beliefs or behaviours cause, or even exacerbate, psychological ill-health. Bartocci (2004) concluded that mystical or religious experiences do have some features in common with psychotic experiences such as delusions, hallucinations, feelings of depersonalisation (Bartocci, 2004), for

example, claiming to 'hear the voice of God'. Jones *et al.* (2003) compared experiences of auditory hallucinations in evangelical Christians with a diagnosis of paranoid schizophrenia (in remission) and a control group of participants who were not Christians and did not have a diagnosis. Those who were in remission described their previous hallucinations as more frightening. However, it was also found that 27% of the control group described auditory hallucinations. These findings have also been replicated by the hearing voices network. Therefore, auditory hallucinations are not in themselves inherently psychotic, whether religious or not.

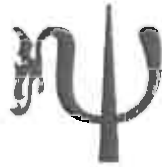
Nonetheless, there is some research to suggest that patients with religious delusions in inpatient settings have more symptoms, function less well and take more medication (Siddle *et al.*, 2002). It could seem that religion has made these individuals unwell. Bhugra (2002) argues that the reverse is true and that individuals who are unwell are attracted to religion. He examined religious histories of first time presenting individuals with schizophrenia in London and found a high proportion had changed their religion and reported an increase in religious activity after becoming unwell.

Appendix 3: The differences between theistic and clinical/humanistic views (Bergin (1980))

**THE DIFFERENCE BETWEEN THEISTIC AND CLINICAL/HUMANISTIC VALUES  
(Bergin, 1980)**

<b>Clinical/Humanistic</b>	<b>Theistic</b>
<p>Humans are supreme. The self is aggrandised. Autonomy and rejection of external authority are virtues.</p>	<p>God is supreme. Humility, acceptance of (divine) authority, and obedience (to the will of God) are virtues.</p>
<p>Identity is ephemeral and mortal. Relationship with others define self-worth.</p>	<p>Personal identity is eternal and derived from the divine. Relationship with God defines self worth.</p>
<p>Self-expression in terms of relative values. Flexible morality. Situational ethics.</p>	<p>Self-control in terms of absolute values. Strict morality. Universal ethics.</p>
<p>Personal needs and self-actualisation are primary. Self-satisfaction is central to personal growth.</p>	<p>Love, affection and self-transcendence are primary. Service and self-sacrifice are central to personal growth.</p>
<p>Open marriage or no marriage. Emphasis on self-gratification or recreational sex without long-term responsibilities.</p>	<p>Committed to marriage, fidelity and loyalty. Emphasis on procreation and family life as integrative factors.</p>
<p>Others are responsible for our problems and changes. Minimising guilt and relieving suffering before experiencing its meaning. Apology for harmful effects.</p>	<p>Personal responsibility for own harmful actions and changes in them. Acceptance of guilt, suffering and contrition as keys to change. Restitution for harmful effects.</p>
<p>Acceptance and expression of accusatory feelings are sufficient.</p>	<p>Forgiveness of others who cause distress (including parents). Completes the therapeutic restoration of self.</p>
<p>Knowledge by self-effort alone. Meaning and purpose derived from reason and intellect. Intellectual knowledge for itself. Isolation of the mind from the rest of life.</p>	<p>Knowledge by faith and self-effort. Meaning and purpose derived from spiritual insight. Intellectual knowledge inseparable from the emotional and spiritual. Ecology of knowledge.</p>

Appendix 4: Information sheet (version 4)



## **SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

**Church leaders' experiences of supporting congregants with mental health difficulties.**

INFORMATION SHEET (Interview)

Version 4 03/09/10

You are invited to take part in a research study which is being carried out by Sarah-Louise Hurst, Trainee Clinical Psychologist, under the supervision of Professor Neil Frude (Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology) and Dr Martyn Baker (Clinical Psychologist, University of East London). The results of the research will be written up as a thesis and submitted as part of the researchers' examinations towards a Doctorate in Clinical Psychology. Before you decide whether you would like to take part please read this information sheet which explains the purpose of the research and how you can help with it. Please feel free to discuss this with others, or contact the researcher (details below) to ask any questions if there is anything you are not sure about, or if you would like more information.

### **What is the purpose of the study?**

Research suggests that religion is important in both the maintenance of wellbeing and recovery from mental health difficulties. Church leaders have long term relationships with members of their congregation and are often consulted by congregants in times of emotional and psychological distress. As a Christian and a Trainee Clinical Psychologist the researcher is interested in the role that church leaders have in supporting people with mental health difficulties.

In May 2010 the Welsh Assembly Government launched 'The Standards for Spiritual Care Services in the NHS in Wales'. The document defined standards for the acknowledgement of spiritual needs in clients in inpatient contexts. However, less is known about how church leaders, often on the frontline working with individuals in community contexts, think and feel about mental health problems. The purpose of this study is to invite church leaders to share their experiences, in order to further understanding.

### **Do I have to take part?**

You are free to decide whether or not you would like to take part, as participation in this research study is entirely voluntary. If you decide to take part, please could you contact the researcher via the telephone, email (details below) or by returning the



reply slip at the end of this document? It would also be helpful if you could return the demographics questionnaire. If you decide to take part you are free to withdraw at any time without giving a reason.

### **What is involved if I do agree to take part?**

If you decide to take part in the research you will be invited to an interview facilitated by the researcher, Sarah-Louise Hurst (Trainee Clinical Psychologist). It is anticipated that the interview will last for 60-90 minutes and take part during the working day. Arrangements will be made for the interview to take occur in a time and place convenient to you. The interview will consist of questions about your experiences as a church leader supporting people with mental health difficulties. The interview and group discussion will be audio-recorded so that the researcher can transcribe the information. The data you and the other participants provide will then be analysed.

After the data has been analysed, the research will move into the second phase. This phase involves presenting the findings from the initial interviews to church leaders, to ascertain how useful they consider the findings to be. This would happen either in another interview, or a focus group format. You would have the option to participate in the second phase, which would last for approximately one hour.

If you agree to partake in the initial interview, there is no obligation to take part in the second phase. You will simply be sent an invite to the second phase, which you can decline. You do not have to make this decision now.

### **What are the possible advantages of taking part?**

You will have the opportunity to contribute to what Psychologists and other health professionals understand about how churches support people with mental health difficulties. It is hoped, in the future, the results of the research may also aid other church leaders and congregants.

### **What are the possible disadvantages of taking part?**

This study is a psychological study and there are no known risks involved in taking part. However, if at any point during the interview or group discussion you feel that you would like to withdraw from the study you will be free to do so.

If you feel concerned by any issues that arise as part of the interview or discussion you would be able to contact Professor Neil Frude to discuss this with him.

### **Will my participation in this study be confidential?**

Your participation in the research and what you said in the interview will be kept strictly confidential, and you will not be able to be identified by anyone other than the interviewer. The questionnaire that you complete will be seen only by the researcher (Sarah-Louise Hurst) and will be kept in a locked filing cabinet. When the discussions are transcribed, all names will be changed so that you will not be identifiable from the transcripts.

### **What will happen to the results of the study?**

The results of the research will be written up as a dissertation and submitted as part of the researchers' Doctorate in Clinical Psychology. Transcribed interview data will be anonymised and so will any information that could allow the participants to be identified. If you would like a summary of the final report you can ask for this when the project is concluded – you will not be identified in this. The results may be published in a journal article.

### **What if I have a problem with the study?**

If you have concerns about any aspect of this study, please contact the researcher (contact details below) who will do her best to answer your questions. If you remain unhappy and wish to complain formally you will be given contact details of the Cardiff University School of Psychology Research Ethics Committee who may be able to respond to your concerns.

### **Who has reviewed the study?**

All research is looked at by a Research Ethics Committee in order to protect your safety, rights, wellbeing and dignity. This study has been reviewed and approved by the Cardiff University School of Psychology Research Ethics Committee.

### **Further information**

If you have any further questions about taking part in the study or require any more information please do not hesitate to contact the researcher (Sarah-Louise Hurst) at the South Wales Doctoral Programme in Clinical Psychology on **02920 206464**, email (Sarah.Hurst@wales.nhs.uk) or return the contact slip to the address below, and you will be contacted as soon as possible.

If you do not wish to take part, you do not have to do anything more, you will not be contacted again. Thank you very much for taking the time to read this information sheet, your help is greatly appreciated.

Mrs Sarah-Louise Hurst  
Trainee Clinical Psychologist

Professor Neil Frude  
Clinical Psychologist  
Research Director

Dominique Mortlock  
Secretary to the Research Ethics Committee  
School of Psychology  
Cardiff University



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Appendix 5: Demographic questionnaire (version 2)



Total number of years working in church leadership (from first post to current post. Leadership is defined as senior position of leadership e.g. vicar, pastor or equivalent).

.....

Please could you give an approximation of how many congregants you have supported with mental health difficulties during your career as a church leader?

.....

Are you currently supporting any individuals with mental health difficulties within your congregation? (Please circle)

Yes                      No

Name (Block capitals): .....

Date: .....



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Appendix 6: Reply slip



**SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY**  
**CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

**Reply slip (first interview)**

Please tick all that apply:

- I am interested in taking part in the research.
  
- I would like more information before I decide whether or not to take part.

The following information is to enable initial contact; it will not be used in the study.

Name: .....

Email Address: .....

Telephone number: .....

Can a message be left at this number?

- Yes
- No

Please return to the address below. If you would like to take part in the research, please also include the demographics questionnaire.

Thank you.



1<sup>st</sup> Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX

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Appendix 7: Cardiff and Vale Local Health Board Research and Design department confirmation letter





**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

**Ysbyty Athrofaol Cymru**  
**University Hospital of Wales**

Heath Park,  
Cardiff, CF14 4XW  
Phone 029 2074 7747  
Fax 029 2074 3838  
Minicom 029 2074 3632

Parc Y Mynydd Bychan,  
Caerdydd, CF14 4XW  
Ffôn 029 2074 7747  
Ffacs 029 2074 3838  
Minicom 029 2074 3632

Eich cyf/Your ref  
Ein cyf/Our ref  
Welsh Health Telephone Network 1872  
Direct line/Llinell uniongyrchol

Tel: 029 20746986  
Fax: 029 20745311  
CAV\_Research.Development@wales.nhs.uk

From: Professor JI Bisson  
R&D Director  
R&D Office, 2<sup>nd</sup> floor TB2  
University Hospital of Wales  
Cardiff  
CF14 4XW

12 July 2010

Ms Sarah-Louise Hurst

Dear Ms Hurst

**Project ID : 10/MEH/4897 : Church Leaders' Experiences Of Supporting  
Congregants with Mental Health Difficulties**

Thank you for your recent communication regarding the above project, which was reviewed on 12 July 2010 by the Chair of the Cardiff and Vale Research Review Service (CaRRS).

Documents submitted for review were:

Document	Version	Date
PRF	3	Received 6 July 2010
Proposal		Received 6 July 2010
Information Sheet: First Interview	2	5 July 2010
Information Sheet: Second Interview	2	5 July 2010
Information Sheet: Focus Group – New	2	5 July 2010
Information Sheet: Focus Group-Original Participant	2	5 July 2010
Participant Debrief Sheet: First Interview	2	5 July 2010
Participant Debrief Sheet: Second Interview	2	5 July 2010
Participant Debrief Sheet: Focus Group	2	5 July 2010
Participant Consent Form: First Interview	2	5 July 2010
Participant Consent Form; Second Interview	2	5 July 2010
Participant Consent Form: Focus Group	2	5 July 2010
Interview Questions	2	5 July 2010
Demographic Questionnaire	2	5 July 2010

I am pleased to inform you that the Chair had no objection to your proposal.

R&D approval and final acceptance of sponsorship by Cardiff & Vale UHB is now subject to evidence of favourable opinion from the School of Psychology Ethics Committee (Cardiff University). Once this is in place, an R&D approval letter will be issued. You should not begin your project before receiving this written confirmation from the R&D Office.

Please ensure that you notify R&D if any changes to your protocol or study documents are required in order to obtain approval from the Ethics Committee.

If you require any further information or assistance, please do not hesitate to contact the staff in the R&D Office.

Yours sincerely,



**Professor Jonathan I Bisson**  
**Chair of the Cardiff and Vale Research Review Service (CaRRS)**

**CC Academic Supervisor, Professor Neil Frude**

Appendix 8: Cardiff University School of Psychology Ethics committee ethical approval confirmation email

From: psychethics  
To: Hurst.Sarahlouuse  
Cc: Neil Frude  
Sent: Wed, 15 September, 2010 14:27:27  
Subject: Ethics feedback - EC.10.08.03.2508RR

Dear Sarah-Louise,

The Ethics Committee has considered the revisions to your postgraduate project proposal: Church leaders' experiences of supporting congregants with mental health difficulties (EC.10.08.03.2508RR).

The project has now been approved.

Please note that if any other changes are made to the above proposal then you must notify the Ethics Committee.

Regards,  
Natalie Moran

School of Psychology Research Ethics Committee  
Tower Building  
Park Place  
CARDIFF  
CF10 3AT

Ffôn /Telephone: +44 (0) 29 2087 0360  
Ffacs/Fax: +44 (0) 29 2087 4858

<http://www.cardiff.ac.uk/psych/research/ethics/>

School of Psychology Research Ethics Committee  
Tower Building  
Park Place  
CARDIFF  
CF10 3AT

Ffôn /Telephone: +44 (0) 29 2087 0360  
Ffacs/Fax: +44 (0) 29 2087 4858

<http://www.cardiff.ac.uk/psych/research/ethics/>

# CARDIFF UNIVERSITY

## SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE

### Committee Decision and Feedback Form

*This project has been scrutinised by the School of Psychology Ethics Committee. The Committee's general remit is to ensure that adequate measures have been taken to avoid any ethical problems that could reasonably be anticipated on the basis of generally agreed ethical guidelines like those set out by the BPS. Approval of a research proposal means that in the Committee's opinion this proposal meets this criterion; responsibility for any breach of ethical conduct rests with the individual researcher. Should any unforeseen problems arise during the conduct of this research, the Chairman of the Ethics Committee (Dr Jacky Boivin) should be informed.*

### Status (decision of the Ethics Committee)

- Approved.
- Approved on condition revisions are made (in consultation with supervisor in the case of undergraduate/MSc projects). Resubmission not required.
- Approved subject to minor revisions (to be dealt with prior to the next meeting of the Ethics Committee).
- Revise and resubmit proposal (to be dealt with at the next meeting of the Committee).
- Revise and resubmit proposal (to be dealt with prior to the next meeting of the Ethics Committee).

---

### Sign-up Poster (i.e. sign-up sheet used to recruit participants)

- Briefly describe the task required of participants.
- Do not 'hype' the advertising of your study.
- Use 12 point font, with standard A4 size, for description.
- Other (see attached sheet).

---

### Informed Consent Sheet (please refer to templates on the web)

- Briefly describe the task the participants are agreeing to perform. The consent form must inform participants of all aspects of the research that might be reasonably expected to influence willingness to participate.
- Promise that the data will be kept confidential OR anonymous and will be used for research purposes only.
- Promise that audio and/or video tapes will be erased, in part or entirely, at the participants' wishes at any time. Please state what arrangements have been made to safeguard private data (e.g.

identified academic and/or medical records, video tapes) during and after the study.

- State how many credits the participants will receive for participation.
  - State that participants may terminate the experiment at any time without loss of promised credit(s).
  - State that there are no known risks to participation or state the risks.
  - State that participants will receive written feedback at the end of the session or study and/or that participants have an opportunity to ask questions about the study at any time before, during and after the study.
  - Other (see attached sheet).
- 

**Written Feedback (feedback participants receive after participating in the study)**

- Elaborate your feedback.
  - Rewrite your feedback at a level that is understandable to a Psychology Level I student.
  - Add a few references at the end and your name and how you can be reached.
  - Other (see attached sheet).
- 

**Other**

- See attached comments.
-

**SCHOOL OF PSYCHOLOGY**

**ETHICS COMMITTEE**

**Committee decision and feedback**

**Project Proposal: Sarah-Louise Hurst (PG) – Church leaders' experiences of supporting congregants with mental health difficulties. (EC.10.08.03.2508RR).**

The Chair of the Ethics Committee considered the above revised proposal and made the following recommendation:

**DECISION: Approved.**

Appendix 10: Consent form (version 4)





**SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY  
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

Version 4  
04/09/10

**PARTICIPANT CONSENT FORM**

**Church leaders' experiences of supporting congregants with mental health difficulties.**

- I understand that this interview will be audio-taped and that I can request that it is turned off at any time.
  
- I understand that my participation in this study will involve being interviewed by the researcher regarding my experiences of supporting members of my congregation who have experienced mental health difficulties. I will also be asked to complete a short demographic questionnaire. This will require approximately 60-90 minutes of my time
  
- I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time, without giving a reason.
  
- I understand that I am free to ask any questions at any time. I am free to withdraw or discuss my concerns with Professor Neil Frude, Clinical Psychologist and Research director on the South Wales Doctoral Programme in Clinical Psychology.
  
- I understand that the information provided by me will be held confidentially, such that only the Researcher can trace this information back to me individually. The information will be retained for up to 5 years when it will be destroyed. I understand that I can ask for the information I provide to be destroyed at any time and I can have access to the information at any time.
  
- I give my permission for extracts from the transcripts to be used in reports of the research on the understanding that my own and my congregants' anonymity will be maintained.

- I understand that at the end of the study I will be provided with additional information and feedback about the purpose and results of the study.
- I also understand that after taking part in this interview I will be sent an invite to take part in the second phase of the research (either another interview or a focus group). I am under no obligation to accept.

I, \_\_\_\_\_ (NAME) consent to participate in the study conducted by Sarah-Louise Hurst, South Wales Doctoral Programme in Clinical Psychology, Cardiff University with the supervision of Professor Neil Frude.

Signed (participant):

Date:

1 copy to participant; 1 to researcher



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## Appendix 11: Extract from an interview transcript

**PARTICIPANT 6**

1 PARTICIPANT 6

2 7<sup>th</sup> January 2011.

3 R (The first question I was interested in was what do you believe enables an  
4 individual to maintain good mental health?)

5 6 I think relationships are vital, <sup>(cause of mh)</sup> good relationships, through family, friends, clubs,  
6 churches, associations, but I think that's vital to a person's wellbeing to maintain  
7 good healthy stable lifestyle. — mental well being

8 R (So relationships are something that's important in maintaining good mental health)  
9 (Is there anything else that you think is key?)

10 6 Well as a Christian I'd have to say faith and belief is a big part, obviously the  
11 people we tend to deal with are people of faith and so trying to encourage them in  
12 their faith and to build up their trust in God is a big part of what we do.  
*element of protective faith*  
*type of support offered*

13 R (And do you believe that trusting in God and faith is an important part of good  
14 mental health?)

15 6 I think it plays a big part yeah. I think when someone is really struggling, whatever  
16 area of their life, if you can sort of point them back to God and say, "Look," you  
17 know, "God cares and loves you and we want to, if you like, affirm that to you by  
18 trying to help you ourselves as a church," I think that is a big part of it.  
*helpful beliefs*  
*role in spiritual support?*  
*imp. of belief*

19 R (So bearing that in mind how do you think good mental health is encouraged within  
20 your church?)

PARTICIPANT 6

6 Well as I say I think relationships are key. I think people are encouraged to be involved in, for example, small groups. We have a small group network so someone new to the church would be welcomed. We have a welcome desk so new people are, hopefully they receive a good, warm welcome and then there's a follow up welcome meal for new people and there's also a small group network.

welcome is important

STRUCTURE OF CHURCH

So it is quite a big church and there's always the danger that people walking in will feel lost and so we try and counter that by putting them in touch with at least a small group of people who will show them loving care.

TYPE OF SERVICE

R (Okay so something about getting involved and being made welcome is a way that good mental health encourages people within the church?)

6 I think so yeah.

R (Is there anything else the church does to encourage it do you think?)  
mental health knowledge in congregation

LESSONS FROM SERVICE

6 Well we do have people in the church who are, if you like, mental health practitioners. We've got a lady who is actually an occupational therapist but her specialism is dealing with people with mental health problems and she actually conducts seminars etc...

deciding who is best to help.

R (Right)

6 ...where the whole question of mental health is discussed and taught. She does that with the backing of ~~WHO~~ and ~~WHO~~ and there's a very good brochure that's been produced, pamphlet, which she hands out at those sessions. So we do have actual, if you like, practitioners in the congregation. We've got a number of occupational therapists who have some experience of dealing with people with

Positive interaction with service

deciding who is best to help.

Appendix 12: Excerpts from the research diary

## **22.12.10**

When listening to some church leaders I find myself thinking 'see, churches do support people well!' I need to be aware of my motivations and assumptions. What are my aims with this project: To legitimise the churches practices? To highlight good practice? To support church leaders? To educate psychologists? To uncover areas of difficulty with how the church support people with mental health difficulties? I need to keep an eye on which aim I am operating in when I am writing.

## **09.01.10**

I am struck by how several church leaders have been so keen to reiterate that they are not the professional, they are the amateur, but for many it has not led them to seek 'professional' help. I wonder if they say this because they think I would consider myself the expert? Or whether they are simply aware of other people in society whose role is based around caring for people with mental health difficulties? What else are they saying or holding back because they are aware of my interests?

## **18.01.10**

In a recent interview I felt like the church leader wanted to 'teach me' what was right to think, which has not happened before. I wondered what is it about the interaction between us that created this? Is it me being a 'professional'? A woman? A Christian? The interview also contained a greater degree of Christian language. It made me wonder how non-Christian researchers would negotiate the Christian language and a reminder to me not to presume I knew what leaders meant without checking. Does the theological framework and Christian language become so useful to communicate, hide behind, or even maybe exercise power that some leaders can forget how to communicate outside of it?

Appendix 13: Inter-rater reliability material: Definitions of randomly selected categories and randomly selected interview excerpts



## **INTER-RATER RELIABILITY MATERIAL: DEFINITIONS OF RANDOMLY SELECTED CATEGORIES AND RANDOMLY SELECTED EXCERPTS**

### **A: Biological causes of mental health difficulties**

This belongs to the category 'Leader's concept of mental health difficulties'. This category contains biological explanations of mental health difficulties.

(30) *"It can be inherited I think. I've come across situations where someone's mother and indeed grandmother have suffered mental health problems".*

(2) *"It's not as simple as circumstantial; sometimes it is something going on in their brain so it is a medical thing as well ... But then sometimes it is circumstance that will lead to the medical problem; so sometimes it's like they have not got enough serotonin in the brain which may lead to depression."*

(20) *"I said, 'look her situation is a very complex situation, I said that she is not just suffering from anxiety or depression, she is chemically imbalanced' ".*

(9) *"Of course there is the genetical aspect where someone can inherit a condition and where there is a chemical imbalance, I think it is approached very differently from when it is not a chemical imbalance".*

(18) *"then there are other things which cause mental health which I genuinely believe are real because they put it down for my wife, it was linked to chemical imbalance-especially as a teenager, there is just something which chemically is not right-do you know what I mean? You can tell. It sometimes it corrects itself I have heard and sometimes it needs some kind of treatment"*

### **B: DISCERNMENT**

This is part of a category 'decision making tools' used to decide whether a difficulty is spiritual or not. Discernment is an 'ability' some people are given by God when they become a Christian which enables them to know when God is telling them things 'are not right' in a situation

(15) *"one of the gifts of the Holy Spirit is the discerning of spirits- what is at work here? and so I think you are able to, as you are talking with someone, and listening to someone the holy spirit himself will begin to guide you and speak to you which sounds a little bit strange I know but that is what Christians believe- God speaks to us".*

(4) *"He actually comes to live within us, to give us the ability to do this and therefore I believe within us, one of the gifts of the Holy Spirit is the discerning of spirits- what is at work here? and so I think you are able to, as you are talking with someone, helping someone and listening to someone the holy spirit himself will begin to guide you and speak to you which sounds a little bit strange I know but that is what Christians believe- God speaks to us"*

(21) *"we have had no formal training in counselling other than what the Holy Spirit has shown us to do and so we come from that angle and you know we generally*

*pray with people, we listen to them, we give feedback, whatever we can do to help. But when I have seen the professionals, it is actually really good because they can come from the paperwork they have to fill in but then they can pray 'Holy Spirit just reveal what it is'.*

*(12) "I think there is a spiritual gift of discernment that erm ... and also experience so the more you go on and the more you see the more you are able to make better decisions. This is something I don't claim to be an expert in so sometimes I realise that I am out of my depth, I need to ask a second opinion so I need to speak to a doctor or somebody who understands this better than I do, to say 'there is this situation, what do you think I should do?' erm...Discernment and experience are the two strongest."*

*(26) "There are checks and balances in that too. Here we have a policy of team work so it is not like 'well if someone has a problem this person will come in and say this is your problem because God told me'. That is very dangerous. So err you know it is listening to someone but I know from experience, if I feel God is speaking to me I will take it very seriously".*

### **C: Spiritual factors impacting wellbeing**

Whilst talking about the causes of mental health difficulties the leaders also described describe the elements of having faith they felt protects against mental health and promotes wellbeing. This category includes elements of being a Christian which church leaders felt were protective against mental health difficulties.

*(17) "err practices in a Christian of prayer, worship and things like that, the disciplines that come with being Christian, the personal disciplines, all make a difference. So I don't think there is one thing, the whole package of being a Christian should impact one's wellbeing."*

*(25) "Purpose helps. If somebody has no purpose then it's very easy...it's easier to get depressed if you have no purpose than if you do have purpose. I think by focusing on somebody else's needs and problems and helping somebody else it helps you."*

*(6) "Peace of God, it's not my flippan answer, that's my most considered answer. Erm yeah. Just err peace with God in its fullness. Not a kind of err an ethereal out there peace with God but genuine spiritual peace which I believe only God can ultimately give."*

*(19) "You know, for me, I've got all my family, I've got all my support network, but actually beyond all that I've got Jesus Christ. I know that he can transcend everything that happens to me. .that he's there, whatever my family do, even if... I lose that support from them ... He is constant. And for me I think that may be one of the things."*

*(22) "Hope that things aren't necessarily going to stay the same, that there's a way forward and that they can see that things can change and get different because*

*we're a church community, a Christian community, that hope we find in God's Word and in God's promises to us."*

#### **D: Lack of understanding of mental health services**

This category refers to how several leaders did not know what mental health services do.

*(8) "I think it would be helpful to know how mental health services fit together, who does what, I think it would be helpful to know a little bit more about some of the medication that people have pumped into them so you know what it is you are talking with and to. It would be helpful to know that sometimes they are not just stabbing in the dark as well when they are treating people with mental health difficulties. Some of what I have seen just looks like sedation until ... and art therapy and stuff like that, well that is great but it would be helpful to understand that a bit more. What it is they are trying to do what they are aiming for. We confuse the terms psychologist, psychiatrists, psychotherapy, it doesn't always make a clear picture of what that is. It would be helpful from a counselling point of view to know".*

*(24) "Sometimes we don't know what is available to help people and talking with them [two psychiatric nurses] I didn't realise the resource and the service that mental health can offer. Sometimes I think we are left a little bit whistling in the dark thinking, what can we do here? Where can we start? Who do I call? I know there is a GP and things like that but I think generally if we knew what was available for people that would help us because maybe it is a closed world like ours is a closed world. It's that you go into this world don't you? Maybe if we knew more about what mental health is all about and what it is trying to do? Is it trying to maintain? Is it trying to heal?"*

*(28) "What this has done for me today is crystallised ... you have done your job well to that extent, highlighting that mental health is an issue, it has got many facets but I wouldn't have known where to go if somebody had presented themselves to me. Maybe I would have just felt out of my depth like last time, so I need to look into that, I need to find out what those external mechanisms are so we can generally point people in the right direction when we can't cope with it ourselves".*

*(1) "I always get confused between psychiatrists and psychologists I think I have another psychologist in the church and I have used him for advice and I have a family member who is a psychiatric nurse as well so when I am getting into areas of mental health I try to work, use them as reference points really at least to know where to point somebody."*

*(23) "I don't really know what a clinical psychologist does ... so I've never referred anybody to a clinical psychologist. I've referred them to counselling ... and yeah I've not really ... given it much thought".*

#### **E: Role of a Christian counsellor**

This refers to church leader's beliefs regarding Christian counsellor's role in supporting individuals with mental health difficulties. It is part of the subcategory

'barriers to accessing mental health services' because it seems church leaders would refer to Christian counsellors rather than considering benefits of mental health services.

(29) *"It would be (a Christian counsellor) every time because you know where their need ultimately lies and where there hope ultimately lies ... the medical profession I'm sure they understand but I just don't think that they understand the spiritual dimension of what we are doing if they are not Christian".*

(5) *"Christian counsellor is the obvious thing for us ... because they... have a slightly different worldview and are coming from a slightly different place. If you believe that the spiritual is involved with virtually everything it is very different to believing that it isn't".*

(14) *"I think most Christians would benefit from a Christian counsellor, just to understand that faith perspective on mental health, anxiety and depression. That can bring it's own pressures and that maybe somebody without a faith at all would find it difficult to get a grip on".*

(16) *"Non Christian counsellors. I wouldn't call on them in a moment of crisis. I would encourage people if they are in touch with them to keep going but they can't offer the gospel like the Christian can. If I had someone who was depressed and I had the choice of sending them to you or to a Christian it would be you every time because you know where their need ultimately lies and where there hope ultimately lies. So yeah, I think Christian mental health counsellors definitely would be really helpful and the medical profession I'm sure they understand but I just don't think that they understand the spiritual dimension of what we are doing if they are not Christian".*

(11) *"I am quite hesitant about referring people to somebody who... pushes their Christianity before their professional status. "I'm a counsellor but I'm a Christian. No I'm a Christian counsellor"... I'd hate to put anybody in with somebody who has got an axe to grind. You know? To do with their faith ... as opposed to dealing with this person's mental health problems".*

#### **F: "Christians should not get ill"**

This refers to an interpretation of the bible (in some areas of Christian culture) which leads people to believe that Christians should not get ill. The category includes thoughts about this belief and consequences of it.

(3) *"If my relationship is right with God then it (getting ill) would never happen. But you know you can always slip as a Christian if you are not going forward you are actually backsliding".*

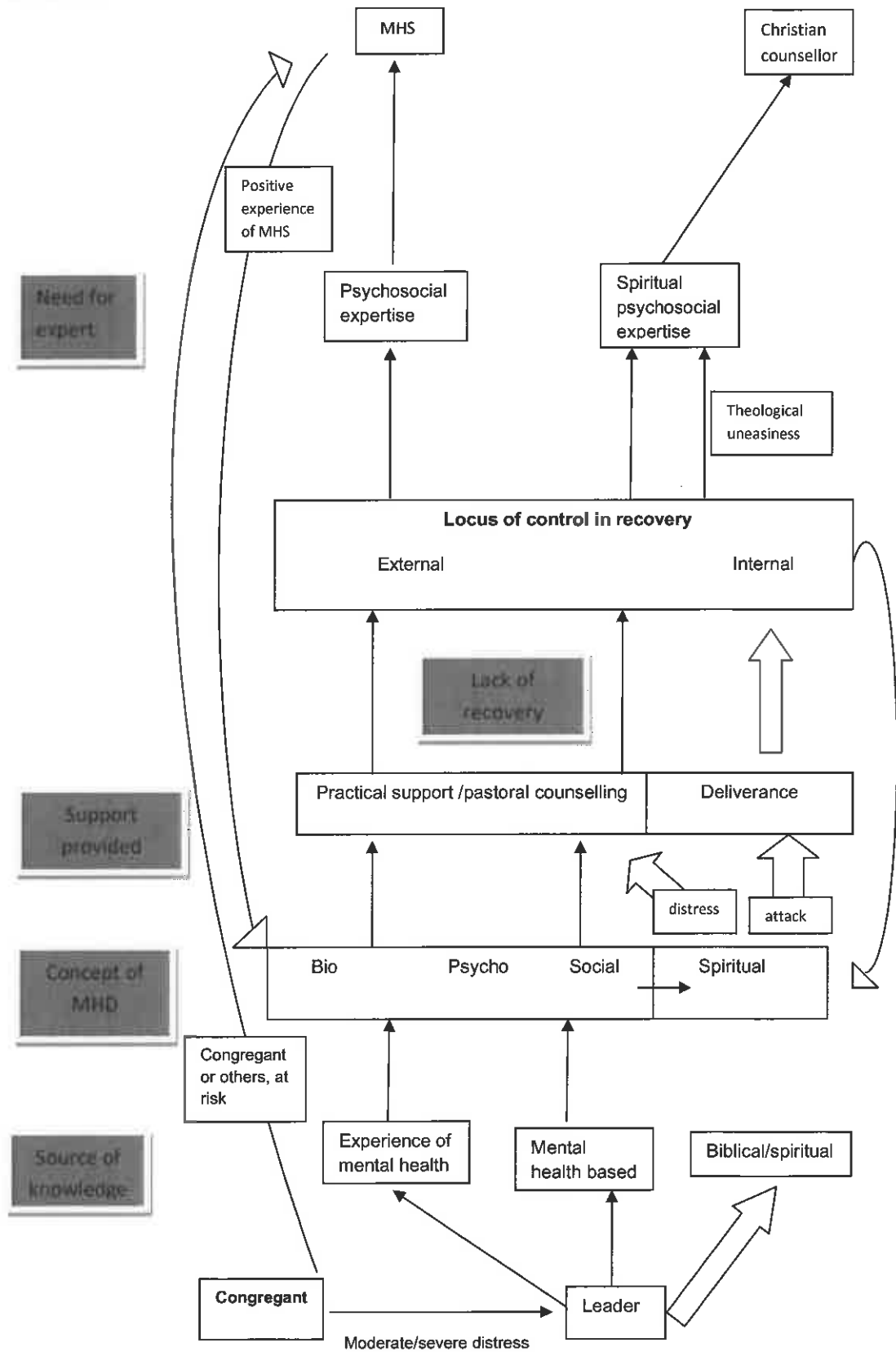
(10) *"Somebody said, "That's not God's plan for you. God doesn't want you to be in this state. You've got to pray for healing". It's like a particular person has put her down because she's not been healed... I think that is awful ... I mean, if I could say why God healed some people and didn't others.. I don't know why that happens. It just does happen, doesn't it"*

(27) *"People think if I'm a Christian, why am I having mental health problems? I think a lot of people think as Christians you're going to be sort of super heroes. And it's not like that ... but we won't talk about it, because I don't think that this should be happening to me".*

(13) *"Perhaps chaplains deal with it more because we are dealing with the sharp edged suffering all the time, if we have a construct where it was all good or all bad then life would be quite easy..good people would be well and bad people would be ill but you couldn't do that because we know that that is not true, we have some wonderful Christians in the mental health unit but they have mental illness, they have depression, they have psychotic episodes and they are no less Christians".*

Appendix 14: Tentative model of how church leaders decide how to support individuals with mental health difficulties

**A model of how church leaders decide what support it best for congregants with mental health difficulties**



## EXPLANATION OF THE MODEL

From my analyses a tentative model of the process church leaders go through in deciding what is the best type of support to offer congregants with mental health difficulties was designed. It is proposed that the organising factor in the type of support considered most apt is the leader's concept of mental health difficulties. Once this was in place the process for each leader was sketched individually and then combined to create this flow-diagram, based around the categories detailed in chapter 3.

The congregant in distress presents to the leader when the distress they are experiencing is moderate to severe (mild distress is supported by other congregants, small groups etc). If the behaviour suggests significant risk to the congregant, or others, the church leader is likely to recommend mental health services. If the distress is moderate to severe and not signifying risk, the leader accesses their concept of mental health difficulties to decide what support is best.

As can be seen in model the wide arrows on the far right signify the church leader who only has access to one source of information (biblical/spiritual), hence can only access one element of an explanatory model (spiritual). Such a leader will provide church based support. However, when there is a lack of recovery the leader perceives 'the need for an expert' to have been met by the church, so will not pursue further expertise.

For other church leaders the more 'sources of knowledge' they are able to access e.g. 'mental health based' knowledge (from training received/medically trained congregants) or 'experiential knowledge' (past experiences of mental health difficulties in congregants, or in family and friends), the wider their explanatory model opens up (bio-psycho-social-spiritual).

All leaders offer the 'support provided' (pastoral/counselling/practical). If the cause of the difficulty is perceived to stem from a 'spiritual attack' (from demons/the devil) prayer for deliverance is likely. If the cause is thought to be 'spiritual distress' the other types of care are offered. The type of support provided starts to further diversify when there is a 'lack of recovery'. The feedback loop from congregant to type of support offered differs here too. If the leader subscribes to an internal locus of control in recovery, (e.g. the individual is not doing enough to recover), then the stuckness is contained within the individual and not the system, the church leader considers it the individual's fault and continues to provide support as before (church based support). If the leader believes in an external locus of control in recovery they considered 'the need for an expert'. The leader may believe a spiritual psychosocial expert is needed (perhaps because of their 'ideological uneasiness' or because they considered the distress to have a spiritual cause) and a Christian counsellor may be chosen. If the leader believes mental health difficulties can have a biological cause, or wants a psychosocial expert, they are more likely to recommend mental health services, than rely solely on church-based support.

A positive experience of mental health services may impact both the concept of mental health difficulties and the likelihood of services being sought again in the future. However, hypotheses from this tentative model require further testing.



## **'HEALING FROM WITHIN: A Guide for Assessing the Religious and Spiritual Aspects of People's Lives'**

Dr Larry Culliford and Rev Dr Stuart Johnson

A reliable way to broach the subjects of religion and spirituality is simply to ask, 'What sustains and keeps you going in difficult times?' A person's answer to this enquiry usually indicates his or her main spiritual concerns and pursuits.

Although several clinically tested screening and **research** instruments are available, the leaflet published here, '*Healing from Within: a guide for assessing the religious and spiritual aspects of people's lives*', is meant to be particularly user-friendly, and suggests sensitive ways of exploring this vital issue more deeply. First published in 2001, it is currently available to staff, patients and carers in hospital and community settings throughout South Downs Health NHS Trust's adult mental health services (South Downs Health NHS Trust Mill View Hospital, Hove, BN3 7HZ).

It has also been distributed elsewhere, and is widely accepted as useful, non-denominational and non-threatening. The leaflet is **also** referred to in a forthcoming Royal College publication<sup>1</sup> which explains something of the rationale behind it. For this reason, this electronic version is being made more widely available. Please copy and use it freely, as you wish. The authors welcome appropriate feedback.

<sup>1</sup> Culliford, L *Healing from Within: Spirituality and Mental Health* in McClure, M (ed). *Partners in Care Resource Pack*. London, Gaskell. Sep 2005.

## **'HEALING FROM WITHIN: A Guide for Assessing the Religious and Spiritual Aspects of People's Lives'**

### **Introduction**

Here is a useful definition of spirituality:

*"A quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes especially into focus at times of emotional stress, physical (and mental) illness, loss, bereavement and death".*

Murray & Zentner (1989):

### **Nursing Concepts for Health Promotion**

Research and experience show that people have religious and spiritual resources to draw on when needed. Here are some questions which may be helpful in opening up this area. A gentle, unhurried approach works best. We offer five headings:

#### ***Setting the Scene***

What do you think life is all about? Is there anything that gives you a particular sense of meaning or purpose.

#### ***The Past***

Emotional stress usually involves some kind of loss, or the threat of loss. Have you suffered any major losses or bereavements? How did they affect you? How did you cope? What helped you to survive?

Is it possible that you gained something from experiencing such a loss? Would you say you were emotionally stronger or more resilient now?

### ***The Present***

Do you have a feeling of belonging and being valued here? Do you feel safe? Are there enough opportunities for meaningful activity? Are you treated with respect and dignity? Are you being listened to as you would wish?

Thinking about what is happening to you now, how would you describe it? Would you say you were having symptoms of mental illness of some kind? Would you prefer another explanation? Would it help to talk, to try and make some sense or meaning out of your life and what's going on? Could there be a spiritual aspect to your problem or your current needs?

Would it help if a room in the hospital was set aside as a quiet place to pray or worship? Would it help you to speak to a chaplain, or someone from your own faith community? Please feel free to say more about your religious background.

### ***The Future***

How do you consider the immediate future? What about the longer term? Do you sometimes find yourself thinking about death and dying? Or about the possibility of an afterlife? Would you like to say a bit more about this?

What are your main fears regarding the future? Do you have any lingering guilt, or feel the need for forgiveness? What, if anything, gives you hope? Is there anything else you would like to say, or ask?

### ***Remedies***

What kind of support do you think would help now? What do you think would be helpful specifically in terms of religious and/or spiritual energy?

Who do you think could best offer any support that you may require, for instance, health professionals, members of your family, or members of your religious community? How will you go about asking for the help you need? What can you do to help yourself?