ELSEVIER

Social Science & Medicine 65 (2007) 548–559

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Challenges to sanctuary: The clergy as a resource for mental health care in the community

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Available online 4 May 2007

Abstract

The transfer of psychiatric care from the institution to the community has presented community structures including faith-based organisations (FBOs) with an additional burden of care. In recent years there has been an increasing policy interest among government departments, public and non-statutory agencies for the inclusion of FBOs as partners in health and welfare services. However, despite their long historical involvement in healing and healthcare, clergy are seldom viewed by mental health professionals as partners in healing and restitution but with suspicion [Koenig, 1988. *Handbook of Religion and Mental Health* San Diego: Academic Press; Larson, Hohmann, & Kessler, 1988. The couch and the cloth: The need for linkage. *Hospital and Community Psychiatry*, 39, 1064–1069]. This may be compounded by ignorance about mental health care provision within FBOs in the UK and the preparedness, confidence and willingness to undertake such care. This paper is based on a study which examined clergy contact with people with mental illness. Thirty-two interviews were conducted with male clergy (Christian ministers, rabbis, and imams) most of whom were London-based. We examine barriers and dilemmas for clergy in caring for people with mental illness. We found that they play an important but often confined role the scale and impact of which is not recognised by their central organisation and training bodies. Low confidence about managing psychiatric problems, underscored by anxiety, fear and stereotyped attitudes to mental illness restrain their willingness to formalise their function. We argue that any proposed extension of clergy involvement in mental health will require further research and thorough deliberation by mental health services and religious organisations.

Keywords: UK; Mental health; Clergy; Help-seeking; Counselling; Faith-based organizations

Introduction

Social capital and community health

Despite the advance of secularism religious and spiritual belief, regardless of form, remains strong (Roof, 1999). In the UK, even though regular church-going activity is reported as less than 8% of the population (Brierly, 2000), 74% of the population claim a Christian affiliation (ONS, 2000), an expression, perhaps, of ethnic or cultural identity rather than commitment (Davie, 1994). Regardless of the rapid change in religious belief, behaviour and organisation there appears to be a renewed social policy interest in the counter-anomic potential of faith-based organisations (FBOs) in the USA and more recently in the UK (Home Office Faith

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doi:10.1016/j.socscimed.2007.03.050

Communities Unit, 2004). Thus, in addition to the private, devotional and symbolic roles of the church, its social function has been long viewed as a community resource for people where religious identities (and other aspects of identity such as ethnicity, class and gender) are affirmed and reinforced. Thus religion provides the basis for association but it also provides a system of shared meanings. In the USA, the black churches have long provided a focus of political mobilisation and also a major welfare function (Hatch & Derthwick, 1992; Veroff, Kulka, & Douvan, 1981).

Religion and help-seeking

Broadly speaking, healing of the individual and of society has been observed as central functions of religion (Csordas & Lewton, 1998; Durkheim, 2001) and, indeed, many of the current health care systems across the world can be traced to religious institutions (Thielman, 1998). There is a considerable body of evidence, predominantly from the USA, that community based clergy have significant contact with people who suffer from mental health problems, many of whom prefer the help of clergy rather than psychiatric professionals (Gurin, Veroff, & Feld, 1960; Larson et al., 1988; Mollica & Streets, 1986; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). In the UK too, there some evidence within the psychiatric pathways literature that religious-based beliefs about mental illness and other misfortune may influence help-seeking and compliance with treatment (Chadda, Agarwal, Singh, & Raheja, 2001; Cinnirella & Loewenthal, 1999; Cole, Leavey, King, Sabine, & Hoar, 1995).

Clergy as carers

While many FBOs maintain a welfare role, the nature or status of this position is unclear, complicated by a range of pastoral and leadership styles between and within religions such as ritual-focussed, pedagogical, charismatic, bureaucratic, democratic or authoritarian and so on (Leavey, in press). In relation to aspects of caring, there is some, albeit limited, evidence that clergy attract favourable comparisons with psychiatrists, reflecting fairly traditional views of clergy as helpful, caring, individuals who offer long-term care to the 'whole person' (Cinnirella & Loewenthal, 1999; Mitchell & Baker, 2000). In particular, where religion or spirituality plays an important role in the life of the individual, clergy are seen as better equipped carers than psychiatric professionals who are contrasted as cold, mechanical, uninvolved and short-term. However, such studies are often based on hypothetical instances discussed by non-patients rather than on comparative experience. Indeed, religious service users offer mixed accounts of their relationship with clergy (Mental Health Foundation, 1997). Despite the demand for greater collaboration between clergy and mental health services we know little about their experience of mental health pastoral care or the willingness of clergy to engage in such partnerships.

The current study

Are clergy able to recognise psychiatric symptoms and are they more tolerant of mental illness than members of the community? The views of mental illness and the mentally ill among clergy are likely to have important implications in terms of pathways to appropriate care and their relationship with psychiatric services, compliance with treatment and outcomes also for their subsequent relationships with their 'church'. Thus, we aimed to examine how clergy from different faith communities, predominantly working in inner-city areas, conceptualise mental illness and provide mental health pastoral care. Importantly, we wanted to adopt a phenomenological perspective in an exploration of clergy experiences and perceptions of dealing with mental health problems in the community. Rather than produce an over-arching theory about pastoral care, the present paper aims to outline and discuss various problems and dilemmas faced by clergy as they attempt to manage mental health problems.

Method

This is a qualitative study using a purposive sampling or theoretical strategy generally associated with grounded theory whereby the collection and analysis of the data are inter-related (Strauss & Corbin, 1990, p. 67). Thus, the data gathered from the preliminary interviews informed the direction of further data collection and informant selection. This helped in the exploration of the parameters of the study and provided opportunities for increasing the 'density' and 'saturation' of significant, recurring and ambiguous categories. For example, non-spiritual explanations of mental illness seemed to predominate in the interviews with white

mainstream Christian ministers while conversely spiritual explanations were significant among black Pentecostals. We therefore sought alternative 'ethnic' voices from these respective faith groups in order to distinguish between ethnic and theological influences. Thus, although Pentecostalism is relatively small in comparison to the more mainstream churches, their 'representation' in this study as a whole may appear stronger than might be expected.

Recruitment and interview

The participants, mostly identified through directories of religious groups, were all contacted by letter and telephone and provided with information about the study. Only two clergy refused to be interviewed (both Pentecostal pastors). The interviews were conducted face-to-face at the ministers' places of worship using a topic guide developed for the study and based on issues that were identified from the literature on religion and mental health. These related to: (a) explanatory models of mental illness; (b) discernment of mental illness; (c) mental health training; (d) aspects of pastoral care; and (e) contact and collaboration with mental health services. The interviewer also attempted to clarify whether beliefs were the personal or idiosyncratic views held by the religious leaders or whether they were generally held by the wider religious organisation and community. The interviews, with two exceptions, were all recorded in accommodation attached to each ministers' place of worship. The purpose of the study was explained to each participant before the interview. Each interview lasted between 60 and 180 min with an average duration of 90 min.

Sample

Thirty-two interviews were completed in a sample that contained 19 Christian ministers, six rabbis and seven imams. The clergy, all men, aged between 37 and 68 years came from a range of religious and ethnic backgrounds. For instance the Christian clergy were English, African, African-Caribbean or South Asian. Where clergy are described as 'mainstream' this is simply to indicate the larger, more established churches in Britain—the Anglican and Catholic. The imams were from Bangladesh (4), India, Turkey and Kenya. The rabbis were all English-born except one person from South Africa. As indicated previously most clergy ($n = 30$) were from London. Although predominantly from deprived inner-city areas, clergy from a range of socioeconomic settings were represented (Table 1).

Table 1
Religious denominations

Christian	Jewish	Muslim
Catholic (5)	Orthodox (3)	Sunni (5)
Anglican (5) (Church of England)	Reform and liberal (3)	Shia (1)
Pentecostal (7)		Sufi (1)
Baptist (2)		

Analysis

Following professional transcription, each transcript was read several times in combination with audio-reviewing in order to check for any transcribing inaccuracies, to facilitate a familiarisation with the broad views of the individual clergy and to form initial ideas and hypotheses. The transcripts were then entered into Hyperresearch, a software programme for the management and coding of text data (Hesse-Biber & Dupuis, 2000). Most qualitative data analysis is seldom achieved using a single definitive approach or style; indeed a repertoire of techniques is generally employed by qualitative researchers to obtain and provide insights into complex phenomena (Denzin & Lincoln, 1994). Coffey and Attkinson (1996, p. 142) call for a balance between a sometimes sterile over-reliance on codes and an over-elaborate intellectual engagement with the data; a compromise between the high transparency of the former and the low transparency of the latter.

All interview transcripts were first analysed by GL using the standard systematic processes of qualitative analysis; descriptive and inferential coding, memoing and data display (Miles & Huberman, 1994). Within a contextualist framework researchers are likely to identify different codes depending, among other things, on training, interests and culture (Charmaz, 1995). Thus, the evolving themes, sub-themes and patterning of issues between and within groups were presented by the first author to the other members of the research team (MK and KL) who had reviewed the transcripts separately. The purpose of the group was to obtain both a consensual and a complementary picture of the phenomenon; thus, these sessions

allowed for a full discussion and validation of the coding and a more rounded theorising of the data (Madill, Jordon, & Shirley, 2000).

In the study as a whole, the primary interest was the categorisation and elucidation of clergy concepts of mental illness and how these relate to wider issues of help-seeking and psychiatric collaboration. Ethnicity, theological variation, literal interpretation of sacred text, culture and secularism evolved as key factors in the analytical framework. However, analysis for this paper focussed on phenomenological aspects of clergy contact with mental health problems in the community. In the preliminary stages, the broader areas or themes covered by the topic guide formed the basis for coding within the major faith groupings. However, as other unanticipated or underlying themes emerged the need for greater individual and intra-group comparisons became increasingly evident.

This paper is divided into the major relevant themes that form the basis for our understanding of the barriers to clergy involvement with me ntal health services. In the first section '*Contact'* we outline the problems of clergy knowledge and recognition of mental illness. While lack of mental health training may be important, theological and cultural considerations, particularly the health beliefs in the wider community, are also relevant. The second '*Clergy vulnerability'* incorporates clergy anxieties about the ability to cope with people with mental disorders who, at times, were perceived as 'extreme', presenting a danger to the clergy and the order of the faith community. An additional danger is that to engage with such people, overstepping a spiritual leadership role, is to dissolve vocational boundaries.

Findings

Key: (A) Church of England; (Ca) Catholic; (P) Pentecostal; (J) Jewish; (M) Muslim; (B) Baptist.

Contact: Typically, clergy across the faith spectrum provide substantial support and comfort to be people at times of crisis or loss; bereavement and separation absorb much of what is considered as pastoral counselling for emotionally or 'spiritually' distressed people. Briefly, the theological framework for this aspect of pastoral support and how it is delivered varies considerably between faith groups but also within faith groups. Often it is a matter of personal history, training, attitude to role or sometimes simply a matter of resources in the local faith community. For instance, a number of the non-indigenous Pentecostal churches, quite disparate in their origins and served communities, are highly active within impoverished inner-city migrant communities (D'epinay, 1969; Martin, 2002). In addition to visible signs of affluence and organisation noted during the fieldwork, several pastors indicated that they are relatively well-resourced and provide assertive outreach programmes among people with mental illness, substance abuse or the homeless. To some extent poverty, social exclusion and ill health are seen by the Pentecostals as evidence of sinfulness, spiritual barriers and secularisation (Leavey, 2004).

The aim (and thus, methodology) of the current study precluded quantification of pastoral time devoted to people with mental illness. In part, quantification depends on illness definition or how one disentangles the emotional, the existential and the spiritual. In the pastoral work of clergy many of these various problems coalesce; although, it can be argued that psychiatry also continues to be confronted by fundamentally similar problems. The participants were generally untrained to assess mental health problems and found this a difficult aspect of pastoral care. Commonly, clergy appeared to counsel and support community members through distressing life events but the amount of care given to cases of anxiety and depression is unknown.

In relation to more enduring or serious mental illness, although such cases are less common, all clergy had occasional or regular contact of varying degrees of intensity with such people. Sometimes these individuals were long-standing and regular members of the faith community or place of worship and 'known' by clergy to have mental health problems. These tend to be individuals for whom the clergy have no knowledge about a diagnosis and the illness has never been formally acknowledged; on a normative assessment, the clergy just know the person is ill—"mostly commonsense" as many participants suggest. Other individuals were known to be in receipt of mental health services and this may or may not be discussed by the individual or his/her family. Clergy, particularly Jewish and Muslim, proposed that in many cases the synagogue or mosque was the first port of call by families when a member of the community experiences emotional or psychiatric problems. However, it was generally the Anglicans and Catholics who experienced the psychiatrically

distressed impromptu callers, often strangers who nevertheless gravitated towards the clergy for material support. Perhaps unsurprisingly, the clergy consider people with comorbidity of mental illness and substance misuse to be the biggest source of anxiety in pastoral care. The management of such people appears to provoke conflict and feelings of guilt among some clergy concerning the charitable ethos of the church and the need for self-protection (Table 1).

Understanding mental health problems

It was not an aim of the study to assess clergy knowledge on mental illness or psychiatry and nor would this be the most appropriate methodology for doing so. However, it may be useful to briefly outline some general observations about the interviews and the issue of knowledge. Among the informants there were three medically trained and qualified doctors, one of whom had been a psychiatrist. Two other clergy had nursing backgrounds in mental health and learning disability. Other clergy had chaplaincy experience in psychiatric hospitals or training in counselling. Generally, however, the participants had received little or no training in mental health as part of their ministry development. Possibly in consequence, evidence of a psychological literacy was variable but more in evidence among the mainstream Christian and Jewish clergy, who, relative to clergy in the other groups, were more likely to have a medical background.

The informants seldom differentiated between psychotic illness and the more common mental disorders such as depression and anxiety. Moreover, in describing those mental phenomena generally associated with psychosis, auditory or visual hallucinations, the boundary between neurosis and psychosis was often presented as blurred, if not inseparable. Thus, for example, one Catholic priest suggested that hallucinations are provoked by stress and depression which ebb and flow in the individual. Or as a Pentecostal minister suggests

> I think it starts from depression—already depressed that something brought you down but some (people) also extremely deteriorate to the level of hearing voices. (P3)

One rabbi differentiated psychosis and 'mild' mental illness in the following way:

> Psychotic is when someone's totally out of touch with reality, has visions or perceptions which do not tally with any rational description of being. Mild ….I would say that people are obsessive or people find it difficult to relate to themselves or to others. (J2)

Thus, mental illness was generally described and discussed by clergy as a continuum of disorder with depression at one end (mild) and psychosis at the other (extreme); the causes of depression and psychotic illness lacked differentiation. Respondents commenting on the differences between depression and psychotic illness characterised the former as less problematic, amenable to treatment, while the latter was deemed as chronic and catastrophic for the individual. Vulnerability to mental illness was described by most clergy as an innate aspect of the individual associated with personality or an inherited trait.

Vulnerability for other clergy, predominantly Muslim or Pentecostal, was also explained in supernatural terms. Where there is literal interpretation of the bible or sacred text (Qur'an), the existence of spirit or demonic possession is indisputable. Thus, unusual and disturbing behaviour in such faith communities may be interpreted by the individual or their family as a religious problem. The imams and Pentecostal pastors stated that they were often contacted by individuals or families who feared that ill-health or misfortune had been provoked by a curse, witchcraft or the result of spirit possession (Bose, 1997). In such cases, prayer and religious rituals such as deliverance (exorcism) were considered to be the appropriate response. As one Pentecostal pastor argued,

> The Bible teaches if you pray you can cast out demons, the problem is that unless it is replaced with something, five demons worse will come. (P5)

As recent high profile child abuse cases in the UK reveal, particular cultural and religious health beliefs or explanatory models of illness among faith communities and clergy can have catastrophic consequences (Laming, 2003). However, while imams appeared to accept the possibility of spirit possession, with varying levels of ambivalence or scepticism, these clergy acknowledge that profoundly stigmatising community attitudes about mental illness tend to determine religious rather than a psychiatric help-seeking for such cases.

Nevertheless, as various imams suggested, spiritual and medical phenomena can be hard to disentangle. One imam who held duties as a hospital chaplain described a pragmatic and inclusive approach to this problem. Whenever contacted by someone possible psychiatric problems he advised both medical intervention and prayer.

> I persuade them to take medicine and in the meantime I ask them to read some verses from the Qur'an so if the problem is from there (spiritual) the verses from the Qur'an will help them and if the problem is from there (biological or psychiatric) then the medicine is needed. We believe that prayer always has the power of healing. (M1)

Clergy vulnerability

Despite an obvious sympathy with the plight of mentally ill people and a vision of their respective places of worship as havens or sanctuaries, the interviews revealed a fear of such individuals, views similar to the stigmatising stereotypes and fears that appear commonly among the general population. These views were expressed candidly and quite unselfconsciously by various clergy. Much of the literature suggests that contact with the mentally ill is a key factor in reducing stigmatising attitudes (Corrigan, 2000). However, despite the undoubtedly high level of contact that some clergy have with the mentally ill, it is only those clergy who have had personal-familial experience or with professional–training who appear to have a more 'relaxed' relationship.

The latter attitude is illustrated by a white Jesuit-trained parish priest, now working in a deprived inner-city area but who had spent some time in Africa. An opening question to him, as with all the informants, was to describe the parish he works in. Before doing so, he insisted on revealing something about his background that he considered relevant. He discussed his older sister, who was severely mentally ill and who had been institutionalised. Thus, while growing up, he visited 'psychiatric wards' and 'mental institutions' once a fortnight, an experience which helps him to deal with mental illness with "absolutely no fear or intimidation of very strange behaviours as some of my colleagues do". While other priests in his parish found the behaviour of mentally ill people hard to incorporate into their ordinary pastoral care, he felt more comfortable about this contact which resulted in parishioners with mental illness usually approaching him rather than his clergy colleagues.

> People do feel what your response is to the situation—and I suppose from a pastoral point of view, if we are going to minister to people with mental health difficulties, then having some degree of being on their wavelength is important. (Ca3)

This 'wavelength' for many of the participants seemed unachievable. The fear of violence perceived to be a correlate of mental illness, inhibited the willingness to engage. Take for example the concerns of an Anglican priest who described the key features of a person with psychosis as chronic, negative, inscrutable, dangerous and threatening. Thus, the priest described psychosis as something much less amenable to intervention, an uncertainty as to what is "going on in that person's mind". To the priest such people frightening because they are much less able to convey their problems and are unpredictable.

> With the psychotic thing, it is different—I think that there is something going on in the head but it doesn't look very nice. (A2)

While dealing with depression was also considered difficult, the priest at least saw the possibility of reflection and negotiation. Another minister observed that the threat of violence is generally present in a psychotic illness.

> They (people with psychosis) didn't want to talk about it they just wanted somebody to agree with their opinion of life otherwise if you didn't—you thought, 'I might get belted here'. The depressed person will want you to give them an answer which is also difficult because you can't give answers to peoples' lives—at least not in one go—it takes a while to talk through". (A1)

Another minister (A3) related how one man came to the church, declaring that God was telling him to kill himself. Again, the fear of violence prompted the priest to avoid being alone with this person, insisting instead that his curate was present. Their response to this man was to reason that God would never tell anyone to commit suicide—they also asked about other problems in his life that provoke his suicidal thoughts. They then asked him "to come into church and pray it out". The man told them he was "being pulled by the dark side" and "he went

off into a different dimension—he felt of course that the devil had got hold of his life''. The priests suggested to the man that he ''needed to get in touch with his spiritual side''. In this case the stranger disappeared and they never saw him again. Although, the clergy did not want to appear unsympathetic to his plight, there is a strong sense of inadequacy about their response to him. The priests want to engage with this man's narrative about his problems—he expressed it in spiritual terms and they respond in kind—to draw him back from the 'dark side'. The problem for these ministers is that if they fail at the first attempt with someone who is unfamiliar to them, they are unable to follow it up. They also have no way of engaging with whatever else is going on in this man's life—no possibility of getting an understanding about his background. They don't rule out seeking medical help or directing to the GP but this is difficult when it is a 'one off' unplanned contact with someone.

Similarly, according to a Baptist minister, (B1) when the community of the church is under threat, a utilitarian approach is often adopted. To illustrate this, he described how a woman in his church that he considered to be mentally ill and ''troublesome to the running of the church''. Her erratic behaviour provoked ''a series of judgements'' against her by the church leaders. In other words they excluded her from the church congregation. He said that he was not so much concerned about her mental health as he was ''for the well being of the community''. When asked what had happened to her, the minister responded that he felt some sense of shame in admitting that the church ''withdrew'' from this person, ''marginalised'' her because she could not conform to the church's demands. An arguably cynical view held by some of the religious leaders, of the patient's motives and linked to the clergy's vulnerability is that some people exploit the historical perception of the caring character of the church. Allied to this, one priest argued that the church cannot deal with these problems/problem people because the clergy are unable to be appropriately tough as this might be dissonant with the perceived or internally cultivated image and values of the church.

> I do find that there are people on the edge who will play out against the church and dump into the church all their difficulties and then the church really can't get a grip of them because the church cannot be unkind. (Ca3)

Religious extremism

There is sometimes a belief that clergy foster (or collude with) the 'excessive' religiosity expressed by some individuals. However, in contradiction of this, the notion of ''religious extremism'' among faith communities was echoed by a range of clergy from different faiths. This was expressed as anxieties about people felt by them to be ''overly-religious'', engaged in ''fanatical'' or obsessional behaviour. Thus, there was clergy consensus that religion attracts people with mental health problems, particularly the more obsessional type. Thus, as one rabbi suggested, religion provides convenient scaffolding upon which to build these obsessions and he feels that he has a ''responsibility to direct them elsewhere for help''.

> … people who become very bizarrely attached to prayer so they pray all the time or they feel very, very guilty if they haven't prayed; or they feel that they have a unique dialogue with God—unique, and I find that bordering on sometimes, not neurosis, almost psychosis! (J4)

Similarly, one priest who was relatively more negative about his pastoral role than other clergy felt that it was hardest coping with people whom he considered ''religious maniacs, slightly obsessional people that you can't get through to''. Such people were often highly religiously observant but often ''the nastiest to the priests outside the context of church''. The priest suggests that this type of person is usually impervious to the hurt that they cause and very difficult for the priest to engage with in order to help them to change their ways. He thinks that somehow there must be a way of excluding the ''lunatic fringe'', as he calls them, from the church.

Intimacy

While clergy proximity and familiarity with the community permits the development of knowledgeable pastoral support, this level of intimacy can also act as a barrier. Thus, close everyday contact with parishioners may create an uncomfortable tension for both the clergy and the sufferer. For instance, one priest describes the usefulness of the confessional where people with difficulties can come and 'off-load', people can be anonymous, and this allows them to talk about their situation. However, beyond the 'box', it may be difficult for his parishioners to continue a counselling relationship.

Thus, the commonly held notion of the clergy as central figures in the community, providing intimacy and continuity may in fact discourage some people from seeking help from FBOs. Contrasted with the very compartmentalised and boundaried relationship that exists between professional counsellors or psychotherapists and their clients, parishioners are likely to see the priest on a regular basis and in routine contexts. Unlike their secular counterparts, they are not socially anonymous or removed—they continue to meet and interact with the parishioners, inside and outside of the church context.

> If someone came to me this afternoon—told me about some terrible problem—I would be seeing them either this evening or certainly tomorrow morning and I think that that can make people a little bit sort of wary of coming for help. (Ca1)

Boundaries

Although dealing with mental health problems was seen by many clergy as a significant part of their work, mainstream Christian clergy, in particular, feel that this has been thrust upon them and that they are not well prepared for it.

> I mean I'm not a counsellor but we do find ourselves in counselling situations. (A2)

Commonly described was the attempt towards a pragmatic but often frustrating management of mental health problems. Thus, one minister (A3) indicated the mandatory caring dimensions of his role; in the lifeworld of the priest dealing with human pain is unavoidable. He then acknowledged his reticence about going "any deeper" into people's problems. Likewise, another priest related how listening to the narratives of people with mental health problems was "difficult and confusing". Of the mentally ill he complained that, "People change their stories".

> It's all very complicated. There is a psychotic end to that and in the midst of it you are wondering what is going on in his mind because the sands are shifting—I'm not going to be able to help this person, you know that very soon. (Ca1)

A general recognition of professional limitations is indicated by mainstream Christian clergy willingness to refer members of the congregation to professional psychiatric help. Thus, pastoral care for most cases is regarded as a stepping-stone. However, in a number of cases there are 'difficult' members of the congregation who are unwilling to seek psychiatric help and whose problems are viewed by unsolvable.

> You can listen and listen and listen but can't actually solve the problems. (A2)
>
> We can get them to express themselves to a certain extent—but there are a lot more situations where you really have to go for proper counselling. You can talk to them and make them feel better temporarily but not in the long term. (Ca3)

Other church members, suspected by the clergy of concealing their mental health problems or who possibly lack psychological insight, present their problems as spiritual. This creates dilemmas for the clergy who do not want to minimise the parishioner's spiritual concerns but find it difficult to engage with such people about possible underlying mental health issues. Thus, one minister felt that there is a danger in attempting to 'spiritualise' a mental health problem because in doing so, the underlying medical problem becomes masked, pushing it beyond treatment. He suggested that there may be a role for religious help but that neurosis should be treated by psychiatry.

> The only danger I would think is, that if you try and spiritualise it you don't get to grips with them …it's almost kind of a repression of what is bothering them and it's not actually going to be dealt with (through pastoral care). (Ca3)

Moreover, many people are stuck with "outdated beliefs" (his words) about sin and guilt and come to him for punishment or absolution but he feels that "like all forms of anxiety and depression it needs to be attacked from different angles". He suggests that psychotherapy may be needed along with religion to resolve some of these conflicts.

Similarly, a rabbi from the Orthodox synagogue finds it very difficult managing people in his community who have mental illness. Discussing the high levels of disorders among young men in the community he observed that families, out of self-blame, try to contain the illness within the family environment as long as possible, leaning on the rabbi for support. His approach was not to "interfere", that is, avoid involvement in such problems and usually encourage such people to get professional help. However, where families insist

on a religious or spiritual aetiology he felt obliged to be more 'confrontational'.

> Usually when there's somebody who's got a mental problem you try to go, you soft pedal with them right, because you don't want to break that confidence. I've learned that actually maybe that's wrong, you have to help them to confront. (J5)

At other times the rabbi has been called to a psychiatric ward by the patient or the patient's family, not to provide spiritual help but to help the person obtain permission to leave. He viewed these patients as quite "manipulative", an attitude which underscored his ambivalent attitude towards dealing with people with mental health problems. Despite being a hospital chaplain he indicated a discomfort in dealing with psychiatric cases adding that it takes up too much of his time. Importantly, he had no desire for additional training and would not wish to become a psychotherapist or counsellor as he asserted that many of his rabbi colleagues have done. Thus, he described himself as a "general practitioner"; a rabbi without specialist training. As far as possible, he avoided counselling to people with mental health problems and instead tended to refer to a mental health professional person attached to his synagogue.

> I'm not a psychotherapist. I don't pretend to be one… alright… and I don't do that cultural counselling. I'm a spiritual carer… ok…I can only be a rabbi. If somebody's got a problem I'll help them. I have to recognise my limitations, alright; I don't pretend to be any psychotherapist. (J5)

However, while such clergy resisted, or were cautious about, blurring the boundaries between secular and religious dimensions of care, an alternative position was articulated indicating that the interconnection between spiritual and psychological causes and expressions of suffering requires a non-polarised healing modality in the help-seeking needs of religious people. One young UK-born imam, a trained psychotherapist, described the difficulties he experienced in trying to reconcile Islamic tenets with psychoanalytic thinking. After much study and reflection, he concluded that the two belief systems were not incompatible

> I mean I feel quite comfortable nowadays working say with a Muslim client for instance where I am thinking in terms of psychological processes and I'm interpreting unconscious processes and so on and yet at the same time you know I'm bringing in say ideas from the Koran or from traditions itself and the Hadiths……and it doesn't seem like an either/or thing you know. (M2)

Discussion

The demand for greater collaboration between FBOs and mental health services by user groups and the voluntary sector may appear sensible, efficient and equitable (NIMHE, 2003; The Mental Health Foundation, 1997). Thus, coupled with an ethos of healing and supporting, many FBO have long standing community-embedded structures. The appeal of FBOs to central and local government seems obvious; for a growing range of ethnically diverse populations the place of worship is a gateway and conduit for policy dissemination and community grievance. As noted here and other studies, they are often a first port of call, particularly in some ethnic minority communities, for distressed individuals and families (Cinnirella & Loewenthal, 1999; Garro, 2003; McCabe & Priebe, 2004).

In some respects, the current study may be considered as exploratory; an attempt to highlight some of the challenges to pastoral care in mental health. Thus, the heterogeneous degree of cultural and theological diversity, even within the Abrahamic religions, makes it difficult to offer a comprehensive view of mental health matters in pastoral care. Indeed, the concepts of pastoral care and spiritual counselling itself tend to have more meaning within the liberal strands of Judeo-Christian traditions. For instance, in the current study, the relative silence of imams on counselling indicates the limited degree to which western, individualist and materialist notions of illness have been assimilated. Moreover, the concerns expressed by clergy in inner-city area may be fundamentally different to those in rural areas. However, to our knowledge there are no studies in the UK which have attempted to examine clergy perceptions of, and engagement with, mental health problems.

The notion of sanctuary

Despite traditionally overly positive, perhaps mythical, views of clergy as sympathetic, caring, insightful etc., the interviews examined here reveal a

more 'realistic', human and complex picture of the world of clergy and mental health pastoral care. Although their collaboration with psychiatry and an expansion of their role in mental health care is advocated by some government bodies and mental health campaigning groups, the evidence here suggests that clergy may be reluctant to be thus engaged. That is not to say that they respond with indifference or disrespect to sufferers but rather there is a strong indication that many clergy, lacking resources and knowledge feel unprepared, vulnerable and intimidated. Thus, generally, clergy may be poorly trained in any aspect of counselling or the management of mental illness and they appear to respond to demands for mental health support with caution and sometimes, rejection.

Strikingly, the low confidence and reticence to provide care among some clergy may be reflected in their perception of the mentally ill as unpredictable and violent. Among mainstream Christians at least, there is a long standing visibility in the community and commonly held notions of Church as sanctuary persist: the concept of sanctuary, embodied in English law between the 4th and 17th centuries, is an enduring part of religious and social folklore; thus the symbolism of church protection remains embedded in the popular imagination. The closure of the old psychiatric asylums and the increasing anomic individualism in society may have resulted in greater demand on clergy from 'difficult' people and difficult to engage patients. Moreover, recent research suggests a high level of verbal abuse and violence against clergy. One such survey found that 12% of clergy in the UK had been physically assaulted and 40% feared becoming a victim of violence while at work (Stanko, 2001). The same report found that many clergy were threatened within their own homes, mostly by callers at the door seeking pastoral care or money. Clergy may be more vulnerable than the general public simply because they embrace an ethos of caring and their vocational role demands 'openness' from them.

Role conflict and role strain: training for pastoral care

Very notable is the low extent to which clergy feel at ease dealing with people with mental health problems and how this easily translates into stereotypes, feeling threatened, incompetent and somewhat guilty about this inability to care for other people in distress. This confirms the opinions of catholic priests in previous UK studies (Louden & Francis, 2003) and evidence from the USA which indicates considerable dissatisfaction with the level of training for pastoral care in ministry to meet the demand for FBO mental health support and counselling (Weaver, 1995). Two obvious suggestions can be made here. Religious organisations and their ministers can either assist people with mental illness, regarding this as a profoundly entwined pastoral and spiritual concern, or, as suggested by some clergy concerned about religious identity and welfare secularism, reject this aspect of pastoral care. The latter does not seem compatible with historical religious provision nor with basic religious precepts across all faiths.

It may seem sensible therefore that this major function and role be put on a more realistic and professional footing. Clergy are the first port of call for many people in their communities; if clergy uncertainty creates delays to professional help, then this demands a greater degree of training on mental health, recognition and counselling. In addition, this will require greater acknowledgement on the part of psychiatric professionals that FBOs are 'frontline' agencies with deep community roots, who may be a valuable tool for early intervention, assisting psychiatry, where appropriate, to reframe patients' causal attributions from the supernatural to the natural. However, regardless of the motivation, would clergy be prepared for a formalised addition to their role?

As we noted among the participants, the acceptance of this type of work complicates the self-image of clergy and was considered by some as corrosive to their primary role of spiritual leader. Thus, the issue of secularisation within religious organisations is a central concern (Pattison, 2000). Clergy may strongly resist adopting and formalising a role outside their religious vocation rather than become "a social worker in a dog-collar", as one priest declared. It is noted that the scope of pastoral care is considerable but in essence it attempts to deal with the problems, concerns and suffering of people within a theological or religious framework (Mollica & Streets, 1986). Thus the essential ingredients of pastoral activity described by church historians are those of guidance, healing, reconciliation, and sustenance of the community. However, it is argued within a Christian context that pastoral care cannot be simply "applied theology", a term which suggests that clergy rely on biblical text to guide their relationships with troubled congregationalists

(Hiltner, 2000). Thus, clergy, when expected to have contemporary skills and relevance, must engage with and learn from an increasing range of modern disciplines and methods including secularist disciplines of psychiatry, psychology and anthropology (among others).

However, if ministers are to engage with other professionals, what then becomes of professional boundaries and the level of cooperation needed (Hiltner, 2000)? Moreover, Pattison suggests that the adoption of professional role models has influenced the individualistic focus of pastoral care in the 20th century. Two major directions are indicated. First, clergy begin to focus more narrowly on religious and spiritual role functions, forsaking more general aspects of their work which was taken over by professional teachers and doctors. Second, clergy begin to adopt a more professionalist stance whereby an emphasis is now placed upon the individual client–professional relationship allied to the increasingly adopted concept that religion is an essentially personal and private matter, "an important predisposing factor towards pastoral care which is psychologically, spiritually and individually orientated" (Pattison, 2000, p. 87). However, pursuing the former direction does not obviate the need, or demand, for basic competency in mental health issues as part of training for ministry, or the development of collaborative links with professional mental health and social welfare agencies.

Conclusions

In conclusion, clergy from all FBOs, willingly or otherwise, play an important but often confused role in the care of people with mental health problems. The scale and impact of this role remains under-recognised by their central organisations and the training bodies who prepare clergy for ministry. Despite calls from user groups and the voluntary sector, UK mental health services continue to neglect a valuable resource in the community and fail to engage with the beliefs and values of religious and spiritually oriented patients (Friedli, 2000; Mental Health Foundation, 1997). However, low confidence about managing psychiatric problems, underscored by anxiety, fear and stereotyped attitudes to mental illness restrain their willingness to formalise this function. Across a number of western societies FBOs seem to have attracted the attention of central government as potential providers of health and welfare services (Maddox, 2001) and there is a strong case for their involvement in mental health care (NIMHE, 2003). The Anglican church has acknowledged the importance of clergy management of mental illness and notes the inherent complexity, sensitivity and possible dangers within spiritual healing (Church Review Group, 2000). However, much more research is needed on the mental health training needs, explanatory models and type of pastoral care that clergy are able and willing to give. We also need a better understanding of how mental health professionals might engage with clergy from different faith communities and accommodate spiritual conceptualisations of illness.

Acknowledgements

Thanks are due to all the clergy who participated in this study. Gratitude also to Barnet, Enfield and Haringey Mental Health NHS Trust for assisting with the resources. This study was supported by NHS Research & Development budget 1.

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