

**THE SACRED, SUPERNATURAL AND SPIRITUAL:
VIEWS AND EXPERIENCES OF FAITH LEADERS
AND CLINICAL PSYCHOLOGISTS CONCERNING
RELIGION, SPIRITUALITY AND MENTAL HEALTH**

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ABSTRACT

Existing research suggest that individuals with mental health (MH) problems and faith-based beliefs are more likely to seek faith leaders (FLs) as a first point of contact rather than MH professionals. However, current knowledge about the extent and role of faith based organisations' (FBO) involvement in MH care and help-seeking is limited and an area seldom explored (Leavey, Dura-Vila & King, 2012). At present there is little data relating to the Mental Health Service (MHS) and FBO relationship including referral patterns and attitudes of FLs towards MHS (Dein, Lewis, & Lowenthal, 2011).

The aims of this study were to understand and explore the views and conceptualisations of London based FLs and UK Clinical Psychologists concerning the relationship between MH and religion and spirituality. It also sought to explore the role and extent of FLs and CPs involvement in MH care with someone with spiritual/religious beliefs, and the experiences and views of FLs and CPs concerning FBO-MHS collaboration.

The study employed qualitative methodology using semi-structured interviews with five CPs and ten Christian FLs. Interview data was analysed using a Thematic Analysis within a critical realist epistemology. Three superordinate themes pertaining to CPs' accounts were developed: 'making sense of religion and spirituality in the context of MH', 'faith talk', and 'partnering with FBOs'. Four superordinate themes emerged in relation to FLs, which captured explanatory models of MH, FLs' practices and roles in MH care, their views and experience of FBO-MHS relationship, and ways to improve FBO relationship with MHS.

Consistent with previous findings were MH practitioners' fear of initiating faith talk and FLs feeling ill-equipped in MH care. The study also highlighted new findings, which include compatible and complementary conceptualisations of MH among FLs that map onto mainstream psychological explanations. Limitations of the present study are discussed, and recommendations and implications relating to

clinical practice, teaching and training, mental health services, policies, and research are made.

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LIST OF ABBREVIATIONS

APA – American Psychological Association

CBT – Cognitive Behavioural Therapy

DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, version 4

FBO(s) – Faith Based Organisation(s)

Faith Leader(s) – FL(s)

Clinical Psychologist(s) – CP(s)

MH(S) – Mental Health (Service)

NHS – National Health Service

UK – United Kingdom

US(A) – United States (of America)

1. CHAPTER ONE: INTRODUCTION

1.1. Preface

Spirituality and religion are significant variables which can contribute towards physical health and mental well-being (Cook, 2011; Cinnirella and Loewenthal, 1999; Fallot, 2001; Neeleman & Lewis, 1994; Pargament, 1997; Macmin & Foskett, 2004; Koenig, Larson & Weaver, 1998). In the past 15 years psychiatrists and psychologists have taken religion and spirituality seriously as an area of academic discourse (Dein, Lewis & Loewenthal, 2011), evident by the increased number of publications concerning religion and mental health (MH) in psychiatric and psychological journals and books (Dein et al, 2011).

There has also been an emerging interest in the relationship between religion and MH; and more recently a growing demand for MH clinicians to take better account of service-users' religious beliefs (National Institute for Mental Health in England, 2003; BPS, 1995, 2009; HPC, 2008) in addition to establishing working links with faith-based organisations (FBOs) as partners in health and welfare (Mental Health Foundation, 1997; Faulkner, 1997). This interest has spurred an increase in government papers and policies to acknowledge the pivotal role that faith leaders (FLs) play as gatekeepers and MH brokers in advising and mediating between government, statutory services and faith communities (e.g., Department of Health (DoH), 2014, 2011, 2009, 2005, 1999). However, current knowledge about the extent, role, and nature of FBO involvement in MH and help-seeking is limited and an area seldom explored (Leavey, Dura-Vila & King, 2012).

At present there is little data relating to the current relationship between the two organisations including referral patterns and attitudes of FLs towards mental health services (MHS) (Dein, Lewis, & Lowenthal, 2011). This study explores links between the MHS, as represented by clinical psychologists (CPs), and

Christian FBO, as represented by FLs. It examines the views and experiences held by both parties regarding MH and spirituality and /or religion, the roles that FLs and CPs occupy when working with someone with MH problems who has religious and/or spiritual beliefs and issues, and the experiences and barriers in FBO-MHS collaboration.

1.2. Literature Review

1.2.1. Literature Search Strategy

Studies of FBO and MH clinicians' views, beliefs, roles and experiences about MH and religion and spirituality, and partnership/collaborative working were identified through computerised searches of the following databases: PsycINFO; PsycARTICLES; CINAHL Plus; EBSCOHost; SAGE Journals Online; The University of East London online library search; British Medical Journals, and Science Direct. Search terms included combinations of the following: "Mental Health", "Faith Healing", "Faith Based Organisations", "Faith leaders", "Mental Illness (Attitudes Toward)", "Mental Health Services", "Psychiatrists", "Clinical Psychologists", "Spirituality", "Religion" and "Attitudes".

Publication dates ranged from 2002 – 2013 with peer reviewed and English language as a criterion. The search yielded 1,077 publications including abstracts and full text articles. Of the 1,077 publications, approximately 20 were deemed suitable and/or relevant to the present study based on whether literature a) pertained to MH and FBO and b) was conducted in the UK as particular attention was given to UK literature. Additional studies were identified and reviewed through references cited by the 20 articles which included non-peer reviewed articles. Other forms of literature were selected from computerised searches via Google search engine and Google Scholar.

1.2.2. Limitations Of The Literature Review

In addition to specificity of geographical location in which literature derived, particular attention was paid to FBO-MHS collaboration and partnership at the exclusion of more broader and generic MH and religion literature. As such, much of the literature esteemed relevant for the present study (i.e., pertaining to mental health, faith based organisations, mental health services, religion and spirituality) relates to psychiatry rather than psychology. There is also a large body of literature concerning religion, spirituality and MH that stretches beyond the scope of this doctoral thesis which is unrelated to FBO and MHS collaboration. Therefore, being appreciative of word constraints and research aims, the

literature used in the review was selected according to relevance, as detailed above.

Furthermore, it is worth noting that the methodological approach employed means that 'unanticipated insights', theory, themes, ideas and models are produced as a result of the research findings (Salmon, 2013; Braun & Clarke, 2006; Howitt, 2010). It is also important to note a potential critique and limitation of literature around the topic area due to gender disparities in status of position among FLs whereby there is an overrepresented of clergymen in leadership roles and an underrepresented of clergywomen in authority or leadership positions (Archbishop Council, 2013; Brierley, 2011). Despite the increase of female FLs in Christian FBO leadership, the implications on literature can disproportionately capture, reflect, and generalise the subjectivity of clergymen as representative of all FLs experiences, views, attitudes and beliefs concerning mental health, religion and spirituality and collaborative practices between FBO and MHS. Therefore, caution should be maintained when considering the reviewed literature and findings.

1.3. Defining Religion, Spirituality and Faith Based Organisations

Historically, religion and spirituality have been notoriously difficult to clarify and there has been a tendency to view them as interdependent and equivalent (Pargament, 1997; Zinnbauer, Pargament & Scott, 1999), which is also evident in literature as almost all studies fail to make a clear differentiation between 'religious' and 'spiritual', and the terms are often used interchangeably. However, despite the plethora of research concerning spirituality and religion, there still remains a lack of consensus of definitions (Swinton, 2001; Carr, 2000; Casey, 2009). Therefore, in the interest of clarity and in order to offer a framework for the concepts of religion and spirituality under study, definitions are provided below.

1.3.1. Spirituality

The divergent forms of spirituality make it a “slippery concept” to define (Swinton, 2001, p.12). It is a problem that in many ways “echoes those that have beset the field of mental health promotion” (Friedli, 2000, p. 8). One of the reasons why there is a lack of conceptual clarity is because it is difficult to capture in words the multifaceted dimensions of human experiences that are often inexpressible and difficult to analyse and conceptualise in science language (Swinton, 2001).

Spirituality is a multi-vocal concept and can be interpreted in numerous ways which are not confined to religion. Although some individuals may express their spirituality through religious values, credence, principles, rituals, and beliefs, it can be contended that belonging to a religion is not tantamount to being spiritual. Indeed, one can be religious and not necessarily spiritual or spiritual but not necessarily religious. While spirituality may relate to religion for certain individuals, for others it may not (Oldnall, 1996). For example, spirituality for an atheist (one who denies God’s existence) or an agnostic (one who is unsure of God’s existence) may centre on beliefs in significant relationships instead of a belief in God (Rassool, 2002). For certain individuals, for instance, Christians and Muslims, spirituality can be directly related to religion (Rassool, 2002); a relationship that is evidenced in the theological literature of that religion.

Literature on spirituality tends to outline the following features: a sense of connectedness to nature, humanity and the transcendent (Post, 1998; Swinton, 2001). The Oxford dictionary (2013) defines spirituality as ‘relating to or affecting the human spirit or soul as opposed to material or physical things’. Swinton (2001, p. 20) offers a more apt and comprehensive definition of spirituality as an “intra, inter and transpersonal experience that is shaped and directed by the experience of individuals and the communities within which they live out their lives.” Swinton expands by saying that spirituality is intrapersonal because it relates to the quest for inner connectivity ; interpersonal because it refers to the relationship between people and communities, and “transpersonal in so far as it reaches beyond self and others into the transcendent realms of experience that moves beyond that which is available at a mundane level” (idem).

Pargament (1997, 1999) also expounds on the definition of spirituality and proposes spirituality as a search for the sacred; a process through which people seek to discover and hold onto whatever they consider to be sacred in their lives. Hill and Pargament (2000, 2003) suggest that the sacred is what distinguishes religion and spirituality from other phenomena; in that the sacred can include concepts of God, the divine, ultimate reality, and the transcendent, as well as any aspect of life that takes on extraordinary character by virtue of its association with or representation of such concepts.

1.3.2. Religion

Religion can be understood as a system of faith and worship, interpreted as an organised entity, such as an institution with certain values, rules, rituals, regulations, practices, customs, and beliefs about God or a higher power other than the self (King & Dien, 1998; Walsh 1999; LaPierre 1994; Horsburgh 1997; Thoresen 1998). The Oxford dictionary defines religion as the 'belief in and worship of a superhuman controlling power, especially a personal God or gods'.

1.3.3. Religion And Spirituality Definitions

By providing contrasts between spirituality and religion it can be helpful heuristics, but there are dangers to this bifurcation of religion and spirituality (Hill et al., 2000; Pargament, 1999). For example, spirituality can become polarised, with either religious or non-religious overtones (Cawley, 1997). However, for the purpose of this study, the following assumptions are made: religion and spirituality are distinct, fluid, but related rather than independent constructs that are not completely interchangeable. Further, the concepts are considered as multi-vocal (Hill et al., 2000), meaning that the terms 'religion' and 'spirituality' are shaped and moulded construct that are uniquely and individually understood (Masters, 2010). Therefore imposed constructs whether that is the use of concrete definitions or a composite of these terms may limit space for understanding individual experiences of spirituality and religion.

1.3.4. Faith

According to Helsel (2010), faith is a construct within a spectrum that expands from the content of a set of beliefs to the act of trust, related to community, doctrine or deity.

1.3.5. Faith Based Organisations

The attempt to define Faith Based Organisations “belies the difficulties involved in providing a robust definition of what actually constitutes FBO” (Lambie-Mumford & Jarvis, 2012, p. 250). Drawing on Beaumont’s (2008, p. 2020) definition, FBO can be understood as “any organisation that refers directly or indirectly to religion or religious values and that functions as a welfare provider and/or political actor”. Inherent in the definition of FBO is a central component of faith, whether that is in the mission statement, the FBO history, its governance mechanisms, or the type of work being done (Chapman 2009). FBO is essentially an organisation which is faith-based and faith-affiliated in its initiatives and activities.

1.4. National and Local Context

Religion is considered to be a defining component of cultural diversity, and therefore important to the research and practice of CPs working in a pluralistic society (Miller, 2003; Cook, 2013) where changes in demographics, as seen below, make religion a salient, rapid and ever increasing and relevant factor (Deleaney, Miller & Bisoño, 2007).

1.4.1. Demographics

In 2011, a UK nationwide survey revealed that of the 56.1 million people living in England and Wales the most prevalent religion was Christianity, with 33.2 million people (59.3% of the population). The second largest religious group were Muslims with 2.7 million people (4.8% of the population). A quarter of the UK population reported having no religious beliefs (Office for National Statistics, 2012). Regionally, London was the most ethnically diverse area, with the highest proportion of minority ethnic groups and the lowest proportion of the White ethnic

group. London was also the most diverse region with the highest proportion of people identifying themselves as Muslim, Bhuddist, Hindu and Jewish (Office for National Statistics, 2012).

In a growing range of ethnically diverse populations a place of worship can be a focal point, gateway and conduit for policy dissemination and community grievance (Leavey et al., 2007). The relevance of FBO to central and local government has resulted in a number of developments in public health policies, guidelines and legislation to push for greater relationships between religion, health, and mental health, which suggest the nature of religion and spirituality and its implications for mental well-being are important issues for MH promotion (Friedli, 2000).

1.4.2. Guidelines, Policies and Legislation

In recent years there has been a surge of UK policy interest amongst government departments, public and non-statutory agencies for the inclusion of FBOs as partners in health and welfare services (NIMHE, 2003; DoH, 1999, 2009, 2005, 2003, 2011, 2014; Home Office Faith Community Unit, 2004; Mental Health Foundation, 2006; Leavey, Loewenthal & King, 2007). This renewed social policy interest in the counter-anomic potential of FBOs in the UK (Home Office Faith Communities Unit, 2004) has resulted in a greater emphasis for both government and statutory services to collaborate with FBOs. There has also been a greater emphasis for MH professionals to take into consideration service-users' spiritual and religious needs as part of assessment, prevention, and intervention. For example, national agendas within the UK describe optimal spiritual healthcare strategies and guidance for working with religious and spiritual beliefs to be given specific attention in national guidelines for the NHS; 'Religion or Belief' (DoH, 2009).

A recent government strategy, '*No Health without Mental Health*' (DoH, 2011) also stipulates the need for services to incorporate religion and spiritual beliefs into the assessment of individuals. A view which is also shared by the World Health Organisation and Health Education Authority (1998), which promulgate the need for holistic understanding of MH. Furthermore, the National Service

Framework for Mental Health (DoH, 1999), DoH (2014), and Delivering Race Equality (DoH, 2005) all highlight the inequalities in MH among that Black Minority Ethnic groups (BME) and prioritise further development of community engagement with FBOs.

'*Closing the Gap*' (DoH, 2014), a more recent paper issued by the government, aims to address local service planning and delivery for the next two to three years, with an emphasis on starting early so as to prevent MH problems occurring. The policy also draws attention to including FBO partnership in MH promotion (DoH, 2014) as a way of enhancing prevention. This policy acts to supplement the '*No Health without Mental Health*' strategy (DoH, 2011) and reiterates the need for working with community leaders, particularly those from BME background, as a way of encouraging more individuals to utilise psychological therapies.

1.4.2.1. *Clinical psychology*: The British Psychological Society (BPS), which act as the clinical psychology voluntary professional body, and the Health and Care Professions Council (HCPC), which operate as the mandatory regulatory body, both stipulate that religion and spirituality are components of diversity that should be factored in when working clinically. However, what this would look like is omitted and the recommendations offered are framed in such a way that is not inclusive with regard to religious diversity (Cooper, 2012).

Both HCPC (2008) and BPS (1995) state that MH professionals must work within their competence and use continuing professional development (CPD) opportunities to address gaps in their competencies. However, the dilemma remains in as much as clinicians will not be challenged by the whole breadth of diversity in religion and spiritual beliefs, thus making the acquisition of competencies in this area difficult. This may be partly due to the discrepancies between those who are referred to psychological services and/or choose to attend and those who are not referred and/or choose not to attend. Issues around referral practices, help-seeking and explanatory models of MH problems also contribute towards whether individuals with religious and spiritual beliefs seek and utilise statutory services or FBOs for help with MH problems.

The tension between professional guidelines which recommend appropriate inclusion of religious diversity, and the lack of clinical psychology training on issues of spirituality and religion (Plante, 2008; Cooper, 2012) can stifle CPD opportunities for developing spiritual and religious competencies. Notwithstanding legislation, policies, guidelines and strategies, there continues to exist obstacles and gaps in MHS-FBO collaboration, with FBOs seldom viewed by the MHS as partners in healing and restitution but with suspicion (Leavey et al, 2007; Koenig, 1998). Reasons for this may be due to a contention that resides between FBOs and MHS in conflicting beliefs and therapeutic modalities used by both parties when dealing with, for example, demonic possession and other supernatural causes of mental health problems (Leavey, 2010).

Leavey et al. (2007) suggest that a confounding factor for the barriers in MHS-FBO collaboration may be due to ignorance about MH care provision within FBOs and the preparedness, confidence and willingness to undertake such care. Similarly, a confounding variable could also be due to MH professionals lack of expertise or/and understanding of religious and spiritual beliefs which may result in those beliefs being overlooked (Pouchly, 2012) and options of collaboration foreclosed. However, against the backdrop of governmental policies and professional practice guidelines, systematic reviews of empirical literature relating to psychology and religion and spirituality indicate that religion and spirituality are still understudied variables in health-related research within psychology (Weaver et al., 1998; Hill & Pargament, 2003).

Hill and Pargament (2003) propose several possible reasons for the neglect of the religion and spirituality variable, such as religion and spirituality being less important to CPs than to the public as a whole (Bergin, 1991; Shafranske, 1996). Furthermore, there could be an assumption that religion and spirituality fall outside the remit of scientific study (Thomson, 1996), and therefore may have some bearing on the tension between professional practice guidelines recommending inclusion of religious and spiritual diversity and the lack of attention given on clinical psychology training courses (Plante, 2008).

1.5. Psychology, Mental Health, Spirituality and Religion

It could be argued that religion has only recently become an area of academic scholarship among psy-professions (psychiatry and psychology), evident by the prolific growth of literature in the past 15 years or so relating to religion and MH in mainstream psychological journals (Dein, et al., 2011; Guthrie & Stickley, 2008), government policies, and MH professional guidelines. However, this is not a novel topic for these fields (Levin, 2010), indeed, scholarship on the topic of religion and MH problems date back to the nineteenth century and are most famously documented in the writings of Freud, who considered the religious practices in the form of the sacred, spiritual and supernatural as pathological (Freud, 1930).

1.5.1. The Supernatural, Sacred, and Spiritual as Pathology: Delineation

Historically, psychiatrists and psychologists have held negative views of religious practices, beliefs and experiences and conceived them as pathological, outdated, and guilt inducing (Freud, 1930; Ellis, 1983); a tradition inspired by Freud's view of religion as an illusion, and a cultural vestige of immaturity and projection (Leeming, Madden & Marlan, 2010). Some of the more influential examples of this tendency include the characterisation of religion as a mass delusion and religious experiences as infantile regression (Freud, 1930; also Ellis, 1983).

Nonetheless, the secular paradigm that has ruled the domain of psychology for the past century has been challenged by late philosophical thinkers such as William James, C. G. Jung, Roberto Assagioli, Viktor Frankl, Erik Erikson, and humanistic psychologists such as Gordon Allport, Erich Fromm, Abraham Maslow, and Carl Rogers (Lemming, Madden & Marlan, 2010). For example, the Rogerian person- centred approach, which emphasises core conditions of therapists being led by the client through being genuineness, showing unconditional positive regard and demonstrating empathy, has provided a contrast to traditional ways of thinking about individuals with religious and spiritual related mental health problems (Lemming et al., 2010).

An increase of transpersonal psychologists during the 1970s may have also prompted efforts to create a synthesis between secular psychology and spiritual traditions (Lemming et al, 2010). This possibly impelled a growing awareness for the need to be inclusive of the religious dimension within clinical practice, and has thus influenced what is now deemed not only legitimate but also clinically and ethically imperative feature of a mental health professional's role (Lemming et al., 2010). However, against the shifts within the secular paradigm, views of religion as pathological and guilt inducing still pervade discourses today, as seen by the prominence of a 'religious delusion' construct in current literature. For example, in western psychology and psychiatry, some religious beliefs, expressions and spiritual experiences are understood as a symptom of schizophrenia, psychosis or religious delusion (O'Connor & Vandenberg, 2005, 2010; Leavey et al., 2012).

Despite the 'religious delusion' construct existing within MH, the DSM (APA, 2000) stipulates that beliefs with religious or cultural origins are exempt from delusional classification and pathognomonic significance, and exemption should be applied without regard to form, content, or consequence of the belief in question. This is a particularly important area, as the field of MH has a long history of considering religious beliefs and experiences as pathological, including those that are "normative" within Western society (O'Connor & Vandenberg, 2005, 2010). However, a chief dilemma in the endeavour to discern religious convictions and expressions from MH distress is the lack of awareness among MH clinicians about religious beliefs that may and can lead to diagnostic inaccuracies and/or inappropriate management (Applebaum, Robbins & Roth, 1999; Koenig, Larson & Weaver, 1998; Koenig, 2009; O'Connor & Vandenberg, 2010).

Such dilemmas may be circumvented by prescriptive adherence to the DSM, but this can result in uncertainty on part of the clinician, who cannot reasonably be familiar with normative beliefs of all cultures, subcultures and religions (O'Connor & Vandenberg, 2005, 2010). It is a quandary which exemplifies the role FBOs have in bridging gaps between understanding the disparities and parameters between MH and spirituality and religion, which are perhaps widened by religiosity gaps between MH clinicians and the beliefs of the general population.

1.5.2. Religiosity gap

There is a high level of involvement from the religious community with FLs taking a primary role in MH, therefore, the questions remains as to why there has not been more collaborative working partnership between FBOs and MHS. Weaver (1998) posits that this is partly due to the disparities between the views of the general population and those of MH clinicians, as there continues to be an under-representation of practicing religious MH professions in MHS compared to the population as a whole. Surveys have consistently found that relative to the general population, CPs are far less religious with regards to affiliation, attendance, beliefs, and values (Cox, 1994; Neeleman & King, 1993; Smiley, 2001; Gallup Foundation, 1996; Office of National Statistics, 2011, 2004; Shafranske & Malony, 1996; Delaney, Miller & Bisoño, 2007; Mayers, Leavey, Vallinatou & Baker, 2007).

A survey conducted by Smiley (2001) found religious disparities between CPs and their clients. These findings corroborate existing literature suggesting the existence of a religiosity gap between clinicians and the general population in which they serve. The religiosity gap may further add to the widespread perception of services being religio-phobic (Leavey, Dura-Vila & King 2012; Weatherhead & Diaches, 2010) by congregants, and contribute towards the uncertainty experienced by some clinicians in understanding religious and spiritual belief and experiences. Perceptions of services being religio-phobic may also create uncertainty among congregants regarding MH clinicians' beliefs and attitude towards religion. Congregants may fear that if they seek help from MHS that their religious beliefs/values will be misunderstood or characterised as pathology, which subsequently inhibits and/or silences the admission of what congregants truly experience (Yarhouse & Fisher, 2002) due to them being afraid to tell (Copsey, 2001; Igboaka, 2010).

1.5.3. Afraid to tell

An area which has attracted academic scholarship is the attitudes and views of psychiatrists regarding religion and FBO (e.g., Dein, Cook, Powell & Eagger, 2010; Dein et al., 2011; Dura-Vila, Hagger, Dein & Leavey, 2011; Foskett, Marriot & Wilson-Rudd, 2004; Macmin & Foskett, 2004; Neeleman & King, 1993). Dura-

Vila et al. (2011) conducted a UK qualitative study of psychiatrists' views on religion and found that psychiatrists avoided engaging with patients' religious beliefs in fear of being perceived as "anti-modern", "unscientific" and "unprofessional" by colleagues and supervisors. Psychiatrists also censored their own religious beliefs and practices within the medical milieu. Additionally, they found that psychiatrists acknowledged the importance of FBOs, but neglected to incorporate this beyond a theoretical level.

The fear of exploring spiritual/religious issues are not confined to clinicians alone (e.g., Macmin & Foskett, 2004). Research conducted in East London, found that service-users were also afraid to talk about spiritual and/or religious beliefs due to fear of being sectioned, placed on medication, or seen as exhibiting psychotic symptoms (Copsey, 2001). Conversely, an audit in North East London NHS Trust found that inpatients were seldom asked about their spiritual needs despite wanting to be asked (Igboaka, 2010). One explanation given is that there remains perpetual fear of speaking about issues which may open 'Pandora's Box' (Dura-Vila et al., 2011), despite recognition that religion and spirituality may be an integral part of a service-users' healing process (Knox, Lynn, Casper & Schlosser, 2005). The implications of which may erect barriers to MHS and perpetuate cycles of neglecting religious and spiritual needs and experiences, which subsequently impact help-seeking behaviour.

1.6. Explanatory Models And Help-Seeking

Over the past 20 years there has been growing interest in literature about the collaboration between MHS and FBO. However, the collaboration between MHS and FBOs can be problematic, particularly in resolution of conflicting beliefs and therapeutic modalities. For example, belief in supernatural causes of MH problems may be contentious among secular MH clinicians, but prevalent in many ethnoreligious communities (Leavey, 2010). Therefore, congregants of FBO may be less inclined to seek help due to the impact of shame, stigmatisation

and cultural insensitivity that can be experienced by some minority and cultural groups (Macmin & Foskett, 2004).

1.6.1. Help-Seeking

Responses to interventions aimed at alleviating MH distress can vary between and within different cultures. For some individuals, the belief that the cause of their emotional distress is a product of sorcery or supernatural interference may influence help-seeking behaviour, in that they may deem it unnecessary to talk to a psy-professionals about their experiences and would find it more relevant seeking help from a FL who specialises in taking away the effects of sorcery through deliverance, rituals or prayer. Similarly, people from cultures that recognise the existence of spirits or Jinn may believe that certain experiences such as hallucinations or indistinct communications are the result of spirit possessions and therefore may prefer to seek spiritual or religious support rather than seeking help that conceptualises hallucinations and spiritual possession as a result of a biological chemical imbalance in need of medication, as would conclude most dominant discourses ¹of mental health problems, e.g. a medical model approach.

Moreover, salient aspects of some FBOs may negatively impact an individual's willingness to seek professional psychological help when MH difficulties arise. For instance, having a belief in divine healing (supernatural intervention by God to heal people from disease) can be a central tenet of faith and praxis. Thus,

¹ Discourses can be understood as a systematic, coherent set of images, and metaphors that construct an object in a particular way as well as it referring to spoken interchanges between people (Burr, 2003). However, Burr (2003) argues that discourses are more than mere abstract ideas and ways of talking about and representing things, they are intimately connected to institutional and social practices that have profound effect on how people live their lives and what they do or have done to them. Burr posits that discourses are tied to structures and practices of society, "and that it is in the interest of relatively powerful groups that some discourses and not others receive the stamp of truth", thus becoming prevailing 'dominant' discourses in society (p. 76).

having a primary dependence on God which is emphasised during times of illness/distress may cause attitudes toward doctors and medication to become disdainful (Griffith, 1998). Subsequently, FBO leaders are likely to be the first point of contact for individuals who attribute MH difficulties to afflictions of the supernatural and spiritual (Khalifa et al., 2012; Cole, 2011; Macmin & Foskett, 2004; Cinnirella & Loewenthal, 1999; Leavey, King, Sabine & Hoar, 1995; Barker, Pistrang, Shapiro & Shaw, 1990; Leavey & King, 2007; Friedli, 2000; McCabe & Priebe, 2004), which may lead MHS to be accessed at points of crisis and desperation.

Weatherhead and Daiches (2010) argue that the utilisation of MHS by FBO can be perceived as a sign of weakness by other members of the community, and that the utilisation of statutory services as a last resort provokes extreme responses, such as involuntary in-patient admission or psychotropic drugs. For some FBO congregants, professional help conflicts with religious beliefs, and as such alters their pathway of seeking help. For example, Cole, Leavey, King, Sabine and Hoar (1995) found that patients and carers during a first episode of psychosis contacted FLs prior to engaging with MHS. In another study Barker, Pistrang, Shapiro & Shaw (1990) found that 17 % of respondents from a nationwide survey of 1040 UK residents preferred to go to a FL for assistance with MH difficulties. Although this was conducted over a decade ago, more recent peer reviewed literature corroborates similar themes of predilections for accessing FBO, for example: Khalifa, Hardie, Latif, Jamil and Walker (2012) conducted a survey with Muslims living within Leicester and found that of 111, 80% reported that they believed in Jinn, of which 60% believed this was the cause of mental illness and that FLs were the chief authority in treatment for MH problems.

Lowenthal (2006) conducted qualitative interviews with orthodox theists and found that they were reluctant to use MHS due to the fear of stigmatisation, having their beliefs pathologised and/or being construed as godless by their community. However, the preference for FBO by minority groups can be due to many factors, such as the elimination of language barriers, inclusion of large families within consultations (Alsam, 1979), shared understanding of beliefs,

cultural context of symptoms, ease of access, being less stigmatising, and maintaining cultural identity. Leavey et al. (2012) suggest that the recognition and interpretation of MH problems by FBO may provide a stark contrast to mainstream secular therapy, which are often considered 'amoral' due to therapy taking a neutral and value-free stance of what are typically religious conceptualisation of problems as a result of sinful behaviour and thought. The authors purport that the "definitive directiveness" (p. 353) offered by some FBO does not equate to secular professionals for whom issues of guilt, morality and conscience are limited in resolution. However, the authors acknowledge that limitations of these views as being polarised and propose that positions are likely to be on a continuum.

Explanatory models of illness and attitudes among FBOs towards psychological problems can also impact recognition of problems, reporting of concerns, help-seeking behaviour, treatment compliance, and efficacy appraisals, in addition to impacting MH utilization rates (McCabe & Priebe, 2004; Kleinman, 1980; Leavey, 2007; Furnham & Malik, 1994; Lafuze, Perkins & Avirappattu, 2002). Therefore, it is important for clinicians to seek a better understanding of the religious worldviews of those they serve.

1.6.2. Explanatory Models

According to Kleinman (1980), explanatory models of illness may directly impact recognition of problems, reporting of concerns and seeking of help. Religious or culturally informed beliefs and attitudes among religious groups toward psychological difficulties can influence and determine help-seeking behaviours (McCabe & Priebe, 2004; Kleinman, 1980; Leavey, 2007), treatment compliance, treatment efficacy appraisals, and impact admission of problems, MH utilization rates and perceptions and beliefs concerning etiology (Chadda, Agarwal, Singh & Raheja, 2001; Cinnirella & Loewenthal, 1999; Furnham & Malik, 1994; Lafuze, Perkins & Avirappattu, 2002). This is congruent with meta-analytic studies and systematic reviews which demonstrate a relationship between religious beliefs and practices and MH (Oppenheimer, Flannelly & Weaver, 2004; Batson, Schoenrade & Ventis, 1993; Worthington, Kuru, McCullough & Sandage, 1996).

FBO may offer a different conceptualisation of MH problems which deflects suspicion and blame away from the individual and/or wider family (Fallot, 2007; Leavey & King, 2007; Leavey et al., 2011). Indeed, the idea of religious solutions that provides an instantaneous 'fix' or confers 'spiritual gifts' may be a more desirable outcome compared to admission, medication or a community treatment order, particularly where individuals look to religion as a means of understanding suffering (theodicy). However, a blame discourse can emerge among some FBOs who conceptualise MH difficulties as a sign of moral or spiritual weakness or failure (Fallot, 2007). These groups may advocate the idea that MH problems can be alleviated if the individual in question "only had adequate faith or strong enough commitments to moral probity" (Fallot, 2007, p. 264). For some FBO the experience of anxiety or depression is linked to spiritual conflict, moral transgression and guilt which propositions the individual as having sinned (Leavey et al., 2012).

Moreover, some FBOs may conceptualise MH within the parameters of medical and psychosocial models rather than a supernatural explanation (Leavey, 2010), which postulates MH problems as a result of misfortune provoked by a curse, sin, witchcraft or spiritual possession (Leavey et al., 2007). For example, Leavey (2010) conducted a qualitative study of beliefs and attitudes among 19 Christian FLs across denominations within the UK concerning supernatural explanations of MH using semi-structured interviews and found that there was no definitive and singular clergy view on the origins of MH problems. In fact, most explanatory models that were expressed by FLs were concerning MH distress and suffering as a result of natural causes rather than a result of sin, punishment and demonic possession (Leavey, 2010).

Conversely, explanatory models of MH within MHS tend to orbit around dominant discourses that are influenced by bio-genetic medical or bio-pyscho-social ideologies and approaches. For example, theories regarding psychosis within psychiatry often gravitate around the idea of biological chemical imbalance that necessitates the use medication, whereas some psychological theories posit trauma as a cause of psychosis (Read, Bentall & Mosher, 2004) or ideas linking to a stress vulnerability predisposition leading to mental health difficulties (e.g. ..

Zubin and Spring's (1977) stress vulnerability model²); and although these conceptualisations of mental health acknowledge a role for social stressors and trauma, it assumes that the vulnerability of experiencing mental health problems is only in those who already have a supposed genetic predisposition (Read et al., 2004).

Conversely, approaches observed within experimental psychotherapies, parapsychology, anthropological studies and mythology provide alternative ways of understanding MH distress and what might be defined as 'psychosis' or 'religious delusion' compared with dominant explanatory models described. For example, Grof (1989) 'spiritual emergency' concept provides an alternative explanatory model of MH distress which incorporates spirituality. The term spiritual emergency implies that both a crisis and opportunity for transformative experience can lead to an emergence of a new level of awareness. The concept is intended to encourage discernment amongst MH professionals in determining whether or not personal growth from an unusual experience can be achieved. Examples of spiritual crisis/emergency include the 'shamanic crisis, the awakening of Kundalini, psychological renewal and individuation, past life experiences, near death experiences and possessions states' (Crowley, 2006, p.6).

It is evident from the literature that FBO leaders have a pivotal role as gatekeeper and brokers in care for services as well as acting as advisors and mediators between government and religious communities (Leavey & King, 2007). However, our knowledge about the extent, role, and nature of FBO involvement in MH and help-seeking remains limited and an area seldom explored (Leavey, Dura-Vila & King, 2012).

² Stress vulnerability conceptualisation of MH proposes that an individual's vulnerability to MH problems is a result of a combination of factors, such as social, biological, psychological, which can be triggered by stressful life events, and thus, lead to MH problems.

1.7. The Role, Extent and Nature of Involvement in Mental Health Care: FBO And Clinical Psychology

Understanding the role and involvement of FBOs and MHS, specifically clinical psychology, when working with service users with spiritual or religious belief, may provide insight to best engage, support and work with UK FBOs as partners in care. Furthermore, elucidating the boundaries of the roles that each party occupies could dispel stereotypes and assumptions that exist to sustain barriers between FBO and MHS. Thus, clarity about the extent and nature of FBO and clinical psychology involvement in MH care could help to facilitate the provision of culturally sensitive community based services.

1.7.1. Clinical Psychology

The ways in which CPs' role have extended to include spirituality and religion within clinical practice can be demonstrated through formulation driven approaches informing intervention (Frazier & Hansen, 2009), conceptualisations of religion as cultural competence (Hodge, 2004; Whitley, 2012), and interagency/community collaboration and engagement. For example, CPs are best positioned to advocate and initiate the process of establishing working partnerships with FBO through community engagement (Pouchey, 2012). Fountain, Patel and Buffin (2007) provide a Community Engagement Model (CEM) framework to facilitate engagement, partnership and capacity building between both organisations (i.e., MHS and FBO).

CEM proposes an intervention which radically challenges traditional consultation processes amongst socially excluded communities in a way that provides a practical and robust means of ensuring that MHS are equitable, appropriate and responsive for all members within the community. The intervention entails MH clinicians helping to create an environment in which communities and agencies can work equitably together to address an issue of mutual concern. It is hoped that by doing so, communities can build capacity and receive regular support, appropriate resources and training. The role of CPs in this capacity would encourage inter- and intra-community participation and networking, and facilitate

the engagement between the statutory and community sectors, such as FBOs (Fountain et al., 2007).

1.7.1.1. *Spiritual Assessment and Cultural Formulations:* Koenig (2008) posits that MH professionals can successfully address service-users religious need by engaging in five activities. These activities include taking a spiritual history, respecting and supporting spiritual beliefs, challenging beliefs, praying with service-users, and engaging in consultation with FLs. Other authors have suggested ways of developing religious and spirituality sensitive assessments which range from prompt questions that aid clinicians to assess issues of religion and spirituality (Puchalski & Romer, 2000) to active engagement with FBO communities (Whitley, 2007). However, in order to deliver care that is culturally valid; CPs need a method that systematically allows them to take cultural, religious and spiritual factors into account when conducting clinical evaluations. One such method that has been used successfully in considering cultural factors is the Cultural Formulation (CF) model (Fernandez & Diaz, 2002).

The CF model supplements the biopsychosocial approach by highlighting the effect of culture on the service-users symptomatology, explanatory model of illness, help-seeking preferences, and outcome expectation. The model is especially necessary when CPs and service-users do not share the same cultural background, since it is then that particular attention to cultural features can be most helpful in orientating the clinical intervention. However, even persons sharing the same race or ethnicity can differ in their cultural backgrounds, as ethnic groups are culturally heterogeneous (Fernandez & Diaz, 2002).

1.7.1.2. *Religious competence as cultural competence:* Attention to religion and spirituality can facilitate the development of cultural competencies and accessible services, which in turn may increase engagement and service satisfaction among religious population (Whitley, 2012; Hodge, 2004). Hodge (2004) proposes three main components of spiritual competence for clinicians: knowledge of their own spiritual world view and biases; an empathic understanding of service-users' spiritual world views and biases; and the ability to develop interventions that are appropriate, relevant, and sensitive to service-

users' world views. Whitely (2012) proposes working in a way that engenders cultural *safety* and cultural *humility*. Whitely suggests that a shift from the notion of cultural competency towards these notions of safety and humility would enable a safe place for discussion of issues pertaining to cultural and religious identities, which can be received in a humble, respectful and empathic manner. This way of being contrasts the technocratic concept of cultural competence which is tantamount with the idea of learning precise skills and competencies to work with service-users from other ethno-cultural backgrounds (Whitley, 2012).

1.7.2. Faith Based Organisations

FBOs have been argued as playing an important role in the deinstitutionalisation, moving MHS of psychiatric care from institutions to the community (VandeCreek et al., 1998; Leavey et al., 2007; Merchant & Wilson, 2010). Many authors, as well as governmental papers, strategies and policies, have recognised the valuable role that FLs play in brokering and facilitating interdisciplinary contact that build alliances between FBO communities and other organisations and services. FBO leaders can act as intermediary gate-keepers and interpreters within and amongst organisations, whether that is in their own congregation or a hospital (Koenig, 1998). FBOs are also known for their wide variety of programs with MH implications, such as providing a place where individuals can receive the friendship of others, the provision of youth activities, prayer groups, soup kitchen, self-help groups, emergency services (funds for food and/or shelter), pastoral visitation, and counselling (Friedli, 2000; VandeCreek et al., 1998). Places of worship can also provide a space where individuals, particularly those who are isolated or unemployed, can meet socially and receive one of few sources of information and support (Friedli, 2000).

Literature that exists on the role and involvement of FBOs in UK MH provision is sparse and there is a general consensus amongst authors that FLs role are confusing and unclear (Leavey et al., 2007). Leavey et al. (2007) postulate that this is due to a wide range of "pastoral and leadership styles between and within religions such as ritual focussed, pedagogical, charismatic, bureaucratic, and democratic" (p. 549). A study conducted by Leavey (2008) examined 32 clergymen from major Abrahamic faith groups about the role and models of

pastoral care for individuals with MH problems and found a significant difference between denominations of Christianity in their approach to MH and MHS, with Anglicans and Catholics FLs viewing medical treatment with religion as complementary. Amongst Pentecostal FLs, there was a belief in the need for collaboration between the church and MHS, due to psychiatrists being 'unable to detect the presence of the demonic' and, therefore, needing greater religious discernment (Leavey, 2008).

Leavey (2008) also found that amongst Christian denominations, counselling was a significant role and activity of the FLs, and often guided by religious principles and frameworks, such as scriptures promoting "good mental and physical health" (p. 84). Leavey concluded that the role of FLs incorporated four main approaches when working with congregants with MH problems: communitarian/ inclusionist; counselling; pedagogic, and healing approaches. The first related to the concern of social inclusion of congregants who experienced MH problems. The emphasis was on care over cure and the inclusion of marginalised groups was an active part of proselytising. The second role proposed was that of a counsellor, particularly amongst Rabbis and Christian clergy. This includes guidance and advice on how to reduce anxiety or manage life events, for instance, relationship problems or bereavement. It involved listening, comforting and advising. Clergy would also assess the origins of the problems and acceptance of secular MHS.

The pedagogic approach entails asserting scriptural teaching in tandem with counselling as there was an expressed reservation amongst clergy about the value of secular forms of talking therapy, which were perceived as either antithetical to religion or at odds with religious beliefs. The final approach, healing, emphasises the importance of intervention through religious cures, rather than solace or coping. It comprises assessment of spiritual problems and treating them through spiritual healing, prayer or, if deemed demonic or oppression, through exorcism or deliverance ceremonies.

It is evident that the role and involvement of FBOs as represented by FLs is vast and varied, and while secular society may resist a health and welfare role for FBOs, the management of MH occupies much of what FBOs do (Leavey et al.,

2012). Whilst the roles of FBOs are important, the scale and impact of these roles are under-recognised by central organisations and training bodies that prepare clergy for ministry (Leavey et al., 2007). Growing evidence of the significance of religious belief to people with MH problems raises important questions about the role of spirituality in MH promotion, the relationship between MHS providers and FLs, and the attitudes of faith communities to MH issues (Friedli, 2000). Concerning the literature, there have only been four major UK studies looking at FLs' attitudes to and experience of religion and MH and MHS, which are discussed below.

Leavey et al., (2007) conducted a study in the UK examining the barriers and dilemmas that clergy experienced when coming into contact with people with MH problems. The authors interviewed 32 London based male FLs including Christian ministers, rabbis, and imams and found that FLs expressed low confidence in being able to manage MH problems and were restrained by fear and stereotyped attitudes of MH problems. Foskett, Marriott and Wilson-Rudd (2004) conducted a study using questionnaires examining the attitude of 89 MH clinicians and 68 FLs in South England regarding MH and spirituality. They found that a majority of FLs saw a link between MH problems and religion, but there was a disparity in responses for whether the link was good or bad with one fifth claiming that religion was a protective factor of MH problems. The authors also found that 73% of FLs referred congregants on to counselling and GP services, and of these, 30% had experience of referring to MHS. In regards to MH professionals, there was an expressed "fear of madness" (Foskett et al., 2004, p. 19) amongst psychiatrists leading to an eschewing of religious and spiritual issues, and a tendency to rely on medicine rather than psychotherapeutic interventions.

Similarly, Cinnirella and Loewenthal (1999) conducted semi-structured interviews examining attitudes of 52 female religious figures from South-South East England from different religious backgrounds towards MH. They found that religious figures were unclear about the role of MH professionals in MH care. The results also revealed a level of fear of being misunderstood by MH professionals, leading to a preference for private coping strategies. They concluded that their findings

supported calls for ethnic-specific MH service provision and highlighted the utility of qualitative methodology for exploring the link between religion and lay beliefs about MH.

A more recent UK based study conducted by Wood, Watson and Hayter (2011) used questionnaires to explore the nature and extent of 39 Christian clergy, across denomination, involvement with people with MH issues within their communities and examined clergy attitudes towards MH and MHS as well as referral practices in the North of England. FLs reported commonly responding to issues of anxiety depression, bereavement and crisis of faith from their congregants, and would refer these individuals on to GP's, private therapies and charities. Conversely, they reported never receiving referrals from anyone other than their colleagues, which suggest some degree of discrepancies in referral direction, which may be indicative of wider collaborative barriers.

FLs also reported the experience of collaborative work with MH professional as negative, with comments such as, "CMHT is inaccessible", "GP insist on prescribing tranquilizers against the patient will for bereavement", "Treated like an inadequate amateur" and "ignored by a hospital when attending with a seriously ill patient" (Wood et al., 2011, p. 778). The authors proposed that the difficulties in collaboration were two-fold: due to a lack of understanding and training within the MHS concerning spiritual issues and a level of scepticism from FLs about the utility of a medical model approach to MH. Despite the negative experience reported by FLs in this study, the majority of the sample called for more collaboration between MHS and FBO. However, a limitation in generalising this study's findings is the overrepresentation of Anglican FLs and low response rate from others denominations.

Religion, spirituality and the clinical practice of psychology are inherently linked due to their vested interested in wellbeing (Cooper, 2012; Myers, 2004); however, despite the ethnic, spiritual and religious diverse population of the UK, the opportunity to engage FBOs with MH care pathways remains neglected. The importance of religion and spirituality in MH is demonstrated by policy and academic research, as elucidated by this review. Clearly, FBOs could form a

major bridge between their communities and statutory services. Therefore, there is a need for MHS and FBO to explore the nature and boundaries of their relationship, as at present there is little empirical data relating to the current relationship between the two organisation including referral practice and attitudes of FLs concerning MHS (Dein et al., 2011). It is also necessary to explore belief systems of FBOs and MH professionals (e.g., CPs) concerning religion, spirituality and MH, as they may influence possible prevention and intervention options (Pouchly, 2012).

1.8. Summary Of Literature And Rationale For Study

Multiple studies have demonstrated that individuals with MH problems with faith-based beliefs tend to seek FLs as a first point of contact. Yet, research indicates little collaboration between MH professionals and FLs. A critical question that remains unanswered is why there has not been more linkage between MHS and FBOs, particularly where FLs act as frontline MH workers (Wood, Watson & Hayter, 2011) for individuals who may not utilise statutory public services (DOH, 2014) and are within possibly hard to reach communities (Aten, Mangis & Campbell, 2010). Literature has recognised the role of FLs being both gate-keepers and MH brokers who have the power to mobilise communication between parishioners, MH professionals, and FBO communities, yet there has been little attention given to the services produced by FBOs (VandeCreek et al., 1998) and the role of FLs in the contribution of and MH care.

It is evident that collaboration between FBOs and MHS could attenuate the difficulty in traversing the boundaries between what MH professionals consider severe and enduring MH problems, such as 'psychosis' and 'schizophrenia', and psychologising strongly held religious or spiritual beliefs (Myers, 2004; Cooper, 2012). The views and attitudes of MH problems among FLs are likely to have an important influence on care pathways, help-seeking behaviour, and their relationship with MHS including utilisation of services, engagement with interventions and ultimately outcomes (Leavey et al., 2007). However, CPs'

knowledge about the extent, role, and nature of FBO involvement in MH and help-seeking is limited and remains an area seldom explored (Leavey, Dura-Vila & King, 2012).

There are several limitations with the body of research available in this field, namely the lack of research in the area of collaboration between FBOs and Clinical psychology services in the UK (Pouchley, 2012). Additionally, literature pertaining to UK CPs' views and beliefs about the impact of MH on religion is thin, which may be due to psychologists' "scant interest concerning the effects of religion on MH" (Loewenthal & Lewis, 2011, p. 256). Research around the topic area of mental health, religion and spirituality is dominated by literature relating to psychiatric, with a focus on male FLs roles, beliefs and attitudes from across faith denominations. No studies have explored only London-based Christian FLs role, views, experiences of collaborative practices, and nor are there currently any studies examining Clinical psychologists experiences and views of collaborative partnership work and their role in working with service users with religious or spiritual beliefs. As a result, there are limitation on the type of conclusions that can be made about the literature reviewed due to the two differences of the two professions – psychiatry and psychology. Therefore, to what extent can inferences be made to inform clinical psychology practices based on the present literature which relates solely to psychiatry?

Furthermore, to what extent does the samples used in the studies discussed reflect a polarised view of FBO attitudes and beliefs regarding mental health and religion and collaboration with MHS, particularly when some denominations are underrepresented and/or from rural areas of England. Would a study using a sample from inner city London with a focus on one faith across denominations yield different findings? And if so, would these findings look different when paired with clinical psychology as oppose to psychiatry? Much of the research presented in the literature review focused on quantitative methodology, with the use of questionnaires and surveys. Methodological issues, such as the type of questions used and how they were asked can restrict exploration around FLs and MH clinicians' experiences, which are phenomenological aspect imperative to understanding the roles and ways in which FLs and mental health clinicians

conceptualise mental and religious and/or spiritual issues as well collaborative practices.

A perennial theme in literature of religion and MH noted by Leavey et al. (2012) is the need for dialogue between FBOs and MHS regarding MH care. However, despite the demand for greater collaboration between FBO and MHS, there is at present little data relating to the current relationships between the Christian FBO and MHS, and views of FLs towards referral to MHS (Dein et al., 2011). There remains a paucity of research in the UK regarding clinical psychology and collaborative practices with Christian FBO, as at present there are no studies that examine UK Clinical Psychologists and London-based Christian FLs views and experiences of religion and mental health and collaborative practices.

Researching these areas may provide potential solutions to increasing cultural *humility*, spiritual awareness, and promote collaboratively working with FBOs in assistance with case management (Dein, 2004; Pouchey, 2010) and addressing access difficulties experienced by certain cultural and minority groups.

1.9. Aims Of Study

In response to issues identified through the literature documented above, the study aims to explore London-based FLs across Christian denominations and UK CPs across specialities in relation to:

- a. Views and conceptualisations about the relationship between MH and religion and spirituality
- b. The role and extent of involvement in MH care of clients or congregants with MH and religious/spiritual beliefs and/or issues
- c. The experiences and views of collaborative FBO-MHS working.

A broader aim of this study is to elucidate the barriers of collaborative partnership between UK MHS and FBOs in a way that bridges gaps between the community and MHS. An offshoot aim is to help consider and promote ways in which clinical,

spiritual, and cultural *humility*, *safety* and awareness can be endorsed, fostered and dispersed between both organisations.

1.10. Research Questions

Following the stated aims, the research questions are:

- a) What are the views and conceptualisations of FLs and CPs regarding MH and religion and spirituality?
- b1) What are the roles and extent of FLs' involvement in the care and management of congregants who experience MH difficulties?
- b2) What are the roles and extent of CPs' involvement in the care and management of service-users who have spiritual or religious beliefs and issues?
- c) What are the experiences and views of FLs and CPs regarding collaborative FBO-MHS partnership work?

2. CHAPTER TWO: METHODOLOGY

This section details the methodology, the rationale for a qualitative approach, epistemological position taken and reflexivity of the researcher, details of the participants, and the method employed in the data collection and analysis.

2.1. Qualitative study

Qualitative methods are appropriate to use where there is little current knowledge about a subject area. It can also be used to help challenge existing assumptions, inform us about phenomenology that have previously been missed, and produce new models and practice ideas for practitioners (Salmon, 2013). Pouchly (2012) suggests that small scale studies exploring the views of MH clinicians and FBOs via the use qualitative research design best aid our understanding of the effect and meaning of the process of integration and collaboration. Pouchly also argues for such studies to be exploratory in nature to find out the perspectives of clinicians and FLs. As stated in the previous [chapter](#), the research aims of this study were exploratory and concerned with “the quality and texture of experience, rather than with the identification of cause-effect relationship” (Willig, 2008, p. 8), suggesting that a qualitative methodology was most appropriate.

The advantages of using qualitative methodology for this study were that it aimed to produce rich, descriptive, and contextually situated data that placed emphasis on processes and meaning, which is of particular importance within clinical psychology (Salmon, 2013). Qualitative methodology also facilitates in-depth study of personal experiences which is well suited to exploratory research (Barker, Pistrang & Elliott, 2002).

2.2. Epistemology

Epistemology can be defined as ‘the study of the nature of knowledge’ and the methods used in which to obtain it (Burr, 2003, p. 202). Epistemological positions

can be characterised by a set of assumptions about knowledge and knowing (Willig, 2012); the epistemological stance can be best understood as what informs how research questions are approached and answered (Willig, 1999; Harper, 2012). Epistemological positions commonly adopted within qualitative psychology vary from radical relativist to naïve realist and there are a range of positions between the endpoints of the continuum (Willig, 2013).

2.2.1. Epistemological Stance: Critical Realism (CR)

An important philosophical position which is relevance to qualitative research in psychology is Critical Realism (Howitt, 2010), which is an elision of the phrases 'transcendental realism' and 'critical naturalism' (Archer, Bhaskar, Collier, Lawson & Norrie, 2013). Critical realists are described as “ontological realists” (Harper, 2012, p .88), inasmuch as they assume that data can tell us about reality but not offer a direct reflection to reality (Harper, 2012). CR is a framework positioned between realism and relativism, which “combines the realist ambition to gain a better understanding of what is ‘really’ going on in the world with the acknowledgment that the data the researcher gathers may not provide direct access to this reality” (Willig, 2008, p.13).

Harper (2012) describes critical realist researchers as having an awareness of the importance of studying qualitative data in detail, as well as considering it important to go beyond text in a broader historical, cultural, and social context. CR acknowledges that reality can be viewed through numerous windows or lenses, which means that each lens or window distorts reality in its own unique way, thus rendering different perspective of reality, depending on which lens is being studied through.

2.3. Research Reflexivity

Reflexivity is an important aspect of qualitative research as it foregrounds and encourages the researcher to reflect upon the ways in which the researcher, as an individual, is implicated in the research and the findings (Willig, 2013). Mauthner and Doucet (2003) postulate that research ‘choices regarding ontological and epistemological positioning, methodological and theoretical

perspective, and the electing of research methods, are inevitably bound up not only with personal or academic biographies, but also motivated exclusively by intellectual concerns. The interpersonal, political, and institutional contexts in which researchers are embedded also play a key role in shaping these 'decisions' (Mauthner & Doucet, 2003), which is why reflexivity means more than merely acknowledging personal biases (Willig, 2013). For this purpose, a reflective journal was kept during the course of undertaking this project (Appendix I). In an attempt to clarify the impact of personal values on this research, this section will briefly outline the researcher's personal views, perspective and frameworks for making sense of the world which influence the research process; influences where are argued as being a strengths rather than a weakness in the research process (Mauthner & Doucet, 2003).

2.3.1. Reflexivity Of Researcher

The reflective journal enabled contemplation on personal beliefs, positions and preconception that could have influenced the research process. In making these visible it is hoped that these aspects are explained, attended to, and consciously present in the decision making process of this study. Several aspects were identified which may have influenced what participants shared in the interview, how they spoke about their experience, the knowledge produced and the interpretations made. These aspects included the intersectionality of the researcher's positions as a: British Female; Christian who is familiar with Christian theology, discourses and expressions; Trainee Clinical Psychologist, and critical realist. These positions will now be discussed below.

Being a Trainee Clinical Psychologist that has engaged with teaching that endorses an ethos of social constructionism within clinical practice has impacted my values and assumptions to be more akin to postmodernist thinking, which in turn has influenced my own epistemological position. Furthermore, attending a training programme that aligns itself closely to community psychology, systemic, and narrative approaches as opposed to more individualists approaches has placed an emphasis on giving voice to marginalised groups, validating and acknowledging the reality of individual experiences, and attending to how

discourses and social context shapes the way individuals' experiences are constructed.

My pre-training experience of working within a Christian FBO impacts my assumptions about some FBO practices towards MH and the potential of adverse influences that some FBO practices can have on vulnerable individuals struggling with mental health problems. These experiences married with my position as a Trainee Clinical Psychologist who has worked with individuals who have expressed spiritual and/or religious related mental health difficulties (e.g., service users who report feeling low in mood as a result of being oppressed by demonic spirits) led to a curiosity about CP and Christian FBO practices when working with religious and spiritual individuals who express concerns of mental health difficulties. These positions, knowledge, experiences, and assumptions potentially influence and impact the process of interviewing and interpreting data. The issues of reflexivity are addressed further in [Chapter 4](#).

2.4. Methodology: Thematic Analysis

A qualitative design using a Thematic Analysis (TA) was adopted within a CR (constructionist) framework, which strategically focused on unpicking and unravelling the surface of reality in discursive formations (Braun & Clarke, 2006) of FLs and CPs' beliefs and attitudes about religion and MH, thus going beyond the semantic content of data to "identify/examine the underlying assumptions, conceptualisations, and ideologies, that are theorised as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p. 84). Although the TA focused primarily at one level (latent), a semantic approach was also employed to consider the explicit surface meanings of the data (e.g., '*How do...*').

TA was chosen among other qualitative analysis (such as Discourse analysis or Grounded Theory) due to the primary intention of wanting to map out the terrain and concourse of ideas and concepts. The benefits of TA are that it moves beyond counting explicit words or phrases and focuses on identifying and

describing both implicit and explicit ideas” (Namey et al., 2008, p.138). TA can usefully summarise key features of a large body of data, such as presented in this study, and offer a ‘thick description’ of the data set. It can also highlight similarities and differences across the data set and generate unanticipated insights, which can be used to inform policy development (Braun & Clarke, 2006).

TA is aligned with a range of ontological and epistemological positions and theoretical frameworks (Braun & Clarke, 2009) as a contextualist method, which can be positioned between two poles of essentialism and constructionism, characterised as CR (Braun & Clarke, 2006). A TA contextualist approach focuses on the ways that individuals make meaning of their experience as well as how broader social context “impinges on those meanings, while retaining focus on the material and other limits of reality” (Braun & Clarke, 2006, p. 81). From a CR perspective, this research aimed to identify manifest themes that are directly observable in the data, whilst also considering deeper latent meaning that incorporates the influence of broader contextual factors using a deduced theoretical TA.

2.5. Participants

2.5.1. Exclusion And Inclusion Criteria

Regarding FL participants, eligibility was narrowed to individuals who were:

- English-speaking
- Over 18-years-old
- In a position of leadership within a Christian denomination. These included pastors, bishops, officers, elders and other positions that assume seniority and responsibility for Christian FBOs.

It was not a requirement for FLs to have had experience of working with parishioners who have MH difficulties, nor was it a requisite for FLs to have historically had contact with the MHS in whatever capacity. The reason for

focusing specifically on Christian FLs was due to the scale and time-limited nature of this project.

Regarding CP participants, the inclusion criteria for eligibility to participate required individuals to be:

- English-speaking
- Qualified as a CP
- Working in the NHS
- Holding an active clinical caseload

CPs who were retired and/or working as researchers without clinical contact were excluded.

2.5.2. Recruitment

Respondents who expressed an interest in participating were provided with information and research consent forms via email and offered the opportunity to discuss the project by phone to address any questions that they had.

2.5.2.1. *CPs*: CPs were recruited through a mixture of convenience and snowballing sampling techniques which involved initiating contact through acquaintances and organisations that acted as brokers in generating interest about the research. For example, The BPS Division of Clinical Psychology 'Race and Culture Faculty' aided the process of recruitment by disseminating the research information sheet (Appendix A1) and consent form (Appendix B) via their mailing list to CPs. CPs then had the choice to express their interest by phone or email. Via the BPS, two CPs expressed an interest and one agreed to participate. Four CPs were recruited through acquaintances.

2.5.2.2. *FBO*: FLs were also recruited through a mixture of convenience and snowballing sampling technique. This approach of recruitment was adopted due to it being used successfully by Cinnirella and Loewenthal (1999).

Three organisations were used to help in the process of recruiting FLs which included 'The Community Psychology Network', London; A London NHS 'Spiritual Care Team', and 'Churches Together', London. All offered to speak to FLs about the research as well as disseminate the research information sheet (Appendix A2) and consent form (Appendix B), which resulted in five FLs expressing an interest, of which four agreed to participate. In addition, an online public electronic directory of FBOs was used to contact 10 FLs via email about the research. Of the 10 FLs contacted, six expressed an interest and agreed to participate in the study.

2.5.3. The Sample

The study had two sample groups with a total of 15 participants: ten FLs and five CPs.

2.5.3.1. *FBO*: Participants comprised of two females and eight males. All of whom held positions of leadership within London based FBOs. Ages ranged from 42 to 83 years, with an average age of 53. Church attendance and membership size varied from 30 to over 10,000 (see Table 1. For more detailed demographic information³).

2.5.3.2. *CPs*: Participants comprised of two females and three males across various specialities and services within London. Ages ranged from 31 to 71 years with an average age of 40 (see to Table 2).

³ All potentially identifiable information has been changed and pseudonyms used to protect the anonymity of participants.

Table 1. Demographic profile of FL participants

Name	Age	Gender	Religious/ Spiritual Beliefs	Denomination	Position in Leadership
Musaka	50	Male	Christian	Pentecostal	Senior pastor
John	48	Male	Christian	Church of England/ Anglican	Vicar
*Tim	46	Male	Christian	Christian Denominational Church	Officer(pastor)
*Susan	—	Female	Christian	Christian Denominational Church	Officer(pastor)
James	56	Male	Christian	Evangelical/Pentecostal	Pastor-in- charge of pastor care
Kofe	42	Male	Christian	Evangelical	Pastor
Alfre	83	Male	Christian	Baptist	Minister
Luke	43	Male	Christian	Non-denominational	Preacher
*Mavis	54	Female	Christian	Pentecostal	Team leader
*Delroy	52	Male	Christian	Pentecostal	Minister

The presence of an asterisk signifies participants who were interviewed in couples.

Table 2. Demographic profile of CP participants

Name	Age	Gender	Religious/ spiritual beliefs	Place of Work	Years of Being Qualified
Sebastian	33	Male	No set belief other than a greater meaning of life	Inpatient Acute and Rehabilitation	2
Malikah	31	Female	Christian	CAMHS	3
Karim	32	Male	Muslim	Early Intervention in Psychosis	2
Farah	32	Female	No response	Forensic Adult Mental Health	1
Jonny	71	Male	Roman Catholic	Neuro-rehabilitation	40

2.6. Ethical Considerations

2.6.1. Ethical Approval

Ethical approval to conduct this research was sought and obtained from the University Of East London School Of Psychology Ethics Committee and a London NHS Research and Development (R&D) Ethics Committee(s) (See Appendix C1 – C3).

2.6.2. Consent

As stated above, respondents who expressed an interest in participating were provided with an information sheet and research consent form via email and in person at the interview. The information sheet provided an overview of the study and contact details. Participants were asked to bring a copy of their signed consent form on the day of the interview. For individuals who had forgot to bring a signed copy, copies of both forms were provided.

At the interview participants were asked whether they had read through the information sheet and had any questions or issues relating to the interview. A verbal recount of the information sheet and interview procedure was given in addition to confidentiality being explained. Participants were also advised of their right to withdraw from the research study at any time without disadvantage to them and without being obliged to give any reason.

2.6.3. Confidentiality And Anonymity

Anonymity was assured by assigning participants codes combining an alphanumerical sequence. These codes, as well as consent forms were kept in a locked cabinet separate to the digital records, transcribed materials, and demographic details. All identifiable information contained in the interviews were anonymised and anonymised quotes from the transcripts were used in the write up of this research. Digital recordings were encrypted and password protected and stored on a secured password-protected computer. Backups of the data were also uploaded onto a secure password-protected data storage websites, with only the researcher and supervisors having access to this material.

Participants were informed verbally and in writing of the above and explained that the transcripts would be kept securely for a period of five years after the study was complete and that after that date all the data and consent forms would be destroyed in accordance with the Data Protection Act (1998). Participants were also informed that should they withdraw, the researcher reserves the right to use anonymised data in the write up of the study and in any further analysis that may be conducted by the researcher.

2.6.4. Distress And Debriefing

Although unlikely, it was possible that the subject area proposed for discussion could have caused distress. As such, participants were forewarned of this and made aware that they could leave the study at any time. Participants were also informed prior to the interview that they could take a break from the interview and return when they felt able to resume. Though unlikely that the issues proposed for discussion would be emotional for participants, it was possible for them to think about or even re-experience difficult events that have happened to them in

the past. As such, contact details of the researcher was at hand for participants for further support in addition to details of local organisations that could provide professional help and support (Appendix D)

2.7. Data Collection

Participants were asked to bring a signed copy of their consent form to their interview, although blank forms were also available at the interview. Participants were offered the choice of meeting at a place of their convenience or the University of East London. Two interviews were carried out in participants' homes and thirteen at places of work or worship. Six FLs were interviewed individually, four were interviewed in couples, and all CPs were interviewed individually. Interviews were conducted face-to-face in a semi-structured format that utilised open-ended questions guided by an interview schedule (Appendix E1 & E2). The interview schedule was used loosely to structure the interview but was not a prescriptive tool adhered to, as space was left for participants to discuss aspects salient to them and to introduce new ideas not previously considered by the researcher. The interview schedules⁴ were designed and developed under supervision around the current research aims and questions, after studying previous research and issues identified from the literature on MH and religion and spirituality.

Participants provided demographic data prior to the interview by completing a pre-interview questionnaire (Appendix F1 & F2), which provided space for written accounts of their spiritual or religious beliefs. Prior to the interview starting, participants were informed verbally that pre-existing definitions of spirituality and

⁴ Once the interview schedule was designed, pilots were carried out on a male consultant counselling psychologist and female Pentecostal FL, respectively; both consented to be interviewed and audio recorded for the purpose of pre-testing the interview schedules (Van Teijlingen & Hundley, 2001). Feedback was ascertained on issues of ambiguity, difficult questions, and wording, and amended accordingly.

religion would not be imposed or used by the researcher but would instead be guided by their use of words and preference of explanation.

Interviews lasted between 11 minutes and 73 minutes and were audio recorded with digital recording equipment, which were later transcribed for analysis.

2.7.1. Transcription of interview data

The transcription process plays an important part of qualitative data (Howitt, 2010; Braun & Clarke, 2006; Willig, 2012) and there are multiple approaches to transcription, with each serving a specific purpose for the style of research (Howitt, 2010). In qualitative analysis, the process of transcription is regarded as a crucial part of the analysis of the data as the researcher becomes familiarised with the content of the interview.

Transcribed interviews were analysed using Thematic Analysis (Braun & Clarke, 2006). Braun and Clarke (2006) posit that TA does not require the same attention to detail as other qualitative methodologies, but it does require a verbatim account of the interview that accurately reflect what was said. As such, interviews were transcribed verbatim with participant's name codified by a number to protect their confidentiality and anonymity. After the initial transcription, interviews were listened to again and compared against the transcription to check for missing information in the write up.

2.8. Data Analysis

The process of data analysis began with engaging with the literature around the topic area, as it is argued to enhance the analysis by sensitising the researcher to the more subtle features of the data (Braun & Clarke, 2006), which is concordant with the deductive theoretical TA of this study. During transcription, handwritten notes were made in a diary to capture any topics or ideas that stood out or had occurred elsewhere across other data sets. The interviews were transcribed sequentially in the order that the interviews took place.

The transcripts and initial notes were then re-read and codes were generated according to sample groups (e.g. CP or FBO) on the margins of each transcript (see Appendix G1a-b for an example). The codes generated were mapped out on an A3 size piece of paper and assigned corresponding participant and transcript line numbers that linked the codes to respective quotes. This process of coding was carried out systematically across the data set for each sample group and required constant comparison between transcripts. Once coding was completed, codes were congregated together (according to sample groups) to form more general, overarching themes. In order to aid this process, codes were written on separate A3 size piece of paper in the form of 'theme mind maps' and then revised and reformed on another A3 sheet of paper until super-ordinate themes and sub-themes were formed (See Appendix G2-G6 for computerised versions).

The collection of themes and sub-themes were then transferred onto Microsoft Excel and refined and reviewed by organising the data extracts within their corresponding themes to assess the level of 'fit' (Braun & Clarke, 2006) (Appendix H1-2). The 'keyness' (Braun & Clarke, 2006) of themes did not warrant quantifiable measures, instead they were based on capturing important aspects in relation to the overall research question; with this in mind, the process of identifying themes anchored around what was important and salient enough, thus worthy of thematising. The criteria by which themes were judged salient enough were informed by research questions. The definitions and descriptions of each sub-theme and super-ordinate theme were discussed and agreed in consultation with the researcher's supervisor (for an example of these final stages of the analytic process, see Appendix G3 & G6).

2.8.1. Validity And Reliability

Reliability within qualitative research can be strengthened by outlining a clear research process, with examples of original data and how the analysis was conducted (Ratcliff, 1995). Validity can be demonstrated by examining whether another researcher can draw similar conclusions through the co-checking of data and interpretations (Ratcliff, 1995). An evaluation of how the study attended to these issues is detailed in the discussion, [Chapter 4](#).

3. CHAPTER THREE: RESULTS

This section has been structured in two parts; the first focuses on the TA of FBO data, which produced four superordinate themes: 'Making sense of MH in the context of religion and spirituality', 'FBO practices and roles: process of help', 'FBO-MHS relationship', and 'Improving relations'. These themes were further divided into subordinate themes, see Table 3. The second part of the results section focuses on the TA of CPs data, and is divided into three superordinate themes: 'Making sense of religion and spirituality in the context of MH', 'Faith Talk', and 'Partnering with FBO'. These themes were divided into subordinate themes, see Table 4. Appendix G4 and G7 contain graphical representation of themes. Quotations from the interviews are provided throughout to illustrate the findings⁵.

⁵ Square brackets are used where modification has been made to quotations and/or information added to explain the text it follows.

Table 3. *FBO Themes and Subthemes*

SUPERORDINATE THEMES	SUBORDINATE THEMES
3.1.1 MAKING SENSE OF MENTAL HEALTH IN THE CONTEXT OF RELIGION AND SPIRITUALITY	3.1.1.1. Preferred: Bio-economic-psycho-social-spiritual 3.1.1.2. Preferred: “Like physical health” 3.1.1.3. Un-preferred “purely Mystical and Spiritual”
3.1.2. FBO ROLE AND PRACTICES: PROCESS OF HELP	3.1.2.1. “Coming Alongside” 3.1.2.2. “Community: The Constitution Of The Church”
3.1.3. FBO-MHS RELATIONSHIP	3.1.3.1. “We are part of the solution” 3.1.3.2. “Professionalisation of Laity”
3.1.4. IMPROVING RELATIONS	3.1.4.1. Intra and Inter Collaboration

Table 4. *CP Themes and Subthemes*

SUPERORDINATE THEMES	SUBORDINATE THEMES
3.2.1. MAKING SENSE OF RELIGION AND SPIRITUALITY IN THE CONTEXT OF MENTAL HEALTH	3.2.1.1. “Real Life Issues” Common Occurrence 3.2.1.2. Religion as a Resource
3.2.2. FAITH TALK	3.2.2.1. Being Led
3.2.3. PARTNERING WITH FBO	3.2.3.1. Internal and External Barriers 3.2.3.2. Ways Forward

3.1. PART ONE. FAITH BASED ORGANISATIONS – FAITH LEADERS

3.1.1. Making Sense of Mental Health in the Context of Religion And Spirituality

Making sense of MH in the context of religion and spirituality was identified as a superordinate theme that mapped onto the study's research question of 'what are the beliefs, views and attitudes among FLs concerning religion, spirituality and MH'. Subordinate themes, interpreted as FLs' preferred and un-preferred beliefs/views of MH, were analysed as representing a dichotomy in FLs' conceptualisation of MH; as it appeared that FLs' talked about their beliefs and views of MH in a polarised manner, placing emphasis on a preferred way of conceptualising MH. FLs explicitly asserted their preferred beliefs as informing and shaping their practice. These beliefs were acquiescent with more secular and westernised models considered as "balanced" and "rational" (Kofe; Luke) ways of viewing MH difficulties; whereas un-preferred beliefs were spoken about as a beliefs that other FLs and congregants hold, which have unhelpful connotations and practices. A majority of FLs reported there to be a relationship between MH and spirituality and religion, which could be beneficial and/or detrimental (e.g. induce guilt and/or assist in recovery). One FL reported there being no relationship.

3.1.1.1. Preferred Belief: Bio-economic-psycho-social-spiritual:

There was a shared view among FLs that MH difficulties were caused by a combination of bio-economic-psycho-social-spiritual factors and that no single factor could act as a primary determinant of MH problems.

"I believe it [MH problem] is mainly caused by depression and stressed [...] various problems that occur in people's lives like marriage, you know financial problems." (Musaka)

"Many people have had mental illness [...] as a short term response to bereavement, many people have it as a response to something anxious

has happened in their life, many people just have it as a natural response of how they've dealt with life really.” (John)

There was also an acknowledgment of fractures within social structures and the impact of economic and political powers, which suggest FLs are cognisant of wider systemic factors and material realities that congregants are embedded in and subject to:

“Everyday peoples mental wellbeing is being played with because they are in jobs and they don't know whether tomorrow they'll have a job, and they don't know, and they've got bills to pay, they've got children raise and there's the worry [...] their mental wellbeing is being played with because they don't know where they stand day to day.” (Mavis)

“I'd be interested to know the correlation between mental health problems and the breakdown of the social structures of this nation.” (Luke)

FLs also drew from biblical explanations to substantiate their explanations concerning the causes of MH and the relationship between spirituality and religion by providing scriptural accounts of religious figures in the bible that are depicted as having experienced MH problems. Biblical accounts were discussed in a way that normalised the occurrence and prevalence of MH problems in society.

“If Christ was to be here how would he treat people with mental problems, and in his time he himself experienced such...” (Musaka)

“In scripture we see that there are individuals who experience depression for example, so we see David in the psalms expressing deep depression being very downcast very forlorn and we see certain individuals, Elijah, sat and he was very downcast and he had these moment of real sullenness [...] what we would now understand or put in the category of mental health issues to whatever end of the spectrum ,and so in one sense it informs the

fact that we are real people dealing with real issues and sometimes these are the real consequences.” (Kofe)

3.1.1.2. Preferred Belief: “Just Like Physical Health”

In addition to the belief that MH problems are caused by multiple interrelated factors, was the view of MH being synonymous with physical health, and therefore on a spectrum:

“...when people have trauma or whatever its deep rooted okay so someone can get born again or whatever but there are scars there or whatever that's true physically [...] and it's the same with mental health in a sense deep trauma and whatever issues that have led to the persons state of mind are going to be there after and are going to take a long time...” (Luke)

“...when [people] hear the word mental health they hear mental but they don't hear health [...] they don't understand that there is a spectrum, and you know, mental health starts with like anxiety and goes all the way to psychosis and that's mental ill health as oppose to mental health [...] it's the same as physical health, if someone asks you about your physical health you don't go to the negative side...” (Mavis)

“I have quite a simple view in relation to mental health um and it's quite simply that in the same way that somebody can become physically unwell or unhealthy likewise um somebody can become mentally unwell and unhealthy and that actually there are many and varying degrees within the field or sphere of mental health ...” (Kofe)

Of particular interest in analysis was the use of physical health as a discourse, which can often be used in MH promotion, whereby stigma and shame are addressed through normalising MH by making it comparable to physical health. Conceptualising MH problems in a way that is understood as being ‘just like physical health’ problems may reflect grand narratives (i.e., stories) popularised through media and public health awareness campaigns that construct MH as an

illness akin to any other illness that one may suffer, which thickens psychiatric/medical model discourse, and this in turn has consequences. The differentiation made by Mavis in distinguish mental *health* from mental *ill* health perhaps epitomises the influence of these dominant MH discourse around disease and illness.

3.1.1.3. Un-preferred “Purely Mystical-Spiritual Beliefs”

A majority of FLs were disdainful of a purely mystical and spiritual view of MH, which purports MH problems as a result of demonic possession or witchcraft. FLs were explicit in dis-aligning themselves from this view but acknowledged that such beliefs exist within Christian FBOs. FLs also spoke about the purely mystical and spiritual belief perpetuating “biblical ignorance” (Luke) among congregants, encouraging stereotyping among MH staff, and exacerbating stigma, shame and guilt of MH problems within the FBO community. FL explained that this impacted help-seeking behaviour and impelled parishioners to “mask problems” (Delroy) due to fear of their integrity of faith being questioned.

“The mystical approach to Christianity um they may see, you know, the cause of mental health issues to be, in their words or their thinking, demonic, and so on it can mean then that help professionals interact with those people more than they may with Christians with a more middle of the road more general view, to the point where they have a stereotype of what it means for a person to have a faith and how that relates to their mental health issues.” (Kofe)

“I believe in the supernatural but ultimately not everything is down to a demon, not everything is down to something other than a person just hurting...” (Luke)

For some FLs, the influence of media and church theology played an important role in perpetuating and endorsing the purely mystical and spiritual explanation of MH which seemed to be associated with inducing guilt, which in turn had implications of stigma, shame, and admission of MH problems.

“... it doesn't help with things that are put on TV [...] and I don't think certain preachers and certain people are helping the situation because then the persons put on a guilt trip and at the end of the day it's not the purpose of a bible believing minister to actually put a person on a guilt trip over a the situation a lot of insecurities as well which occurs so for me I believe churches ill equip to deal with mental health generally.” (Luke)

“There are some extreme churches that would think it was a failure of faith for any of their people with mental health [...] it would be better by far almost for churches to draw together where a lot of love and healing takes over.” (Alfred)

“...the theology of that church didn't really help and almost added on another layer of guilt that it was somehow her fault ...” (Tim)

There was also concerns that taking a purely mystical-spiritual view could lead to unhelpful practices such as the “just pray” approach, which endorses only spiritual interventions, at the exclusion of other interventions. A combined perspective that embraces medical and spiritual approaches was considered a more advantageous way of understanding MH difficulties.

“I believe in trusting as you pray but also to consult with doctors and professors, even in counselling, you know. Some people believe just simply you have to do it in a spiritual way ‘pray, pray, pray, pray’, even if your situation deteriorates, and they say that is maybe God's will but I don't believe in that [...] I always advise people, those who are suffering with mental problems to consult the profession like in counselling and doctors and at the same time we trust in God through prayer.” (Musaka)

“Where we were talking about mental ill health, prayer and the medical intervention work hand in hand, and that's where we are coming from, we don't leave one for the other, where we think one is strong than the other, we actually working with both to, so that the individual is supported...” (Mavis)

The idea of faith complementing rather than conflicting with MH was reiterated by a majority of FLs, with most stating that they would encourage congregants to adhere to medical recommendations. These views may be influenced by wider political and legal discourses around risk (e.g., faith-based abuse). Indeed, several FLs spoke about being mindful of ethical obligations and legal implications and penalties of religious practice linked to abuse:

“Only the couple decades the responsibility of churches for the wellbeing of their congregation has become highlighted in national situation, so in courts faith leaders have had to answer why have this situation existing in your church and why was that ignored to the point that a church or an individual life has been lost...” (Delroy)

“When high profile cases hit the headline and there's a sense of okay as a church as a Christian community we have to consider amongst ourselves how we view and respond to these types of situations when they arrive so that good practice is shared, so that people are most ably assisted and that tragedies can be avoided and averted.” (Kofe)

Overall, the data suggest that FLs are aware and attuned to dominant concepts and assumptions about MH problems as an acceptable lens through which they make sense of MH difficulties:

“I might not share some of the fundamental convictions that are foundational to the mind sciences but in terms of research and factual observations and findings there might be things that I am able to look at and see there is truth there...” (Kofe)

3.1.2. FBO Practices and Roles: Process of Help

An important aspect of this research was to examine FBOs' involvement in MH care. The process of help captures aspects of FLs' role and involvement in helping someone with MH problems, and practices and approaches used in 'coming alongside' someone to provide support, build capacity, assess need, and signpost. It also captures the importance of 'community' in promoting prevention, addressing stigma and challenging inequitable services.

3.1.2.1. "Coming Alongside"

'Coming alongside' was a significant feature of the FLs' role in MH care. This theme cut across all interviews and was analysed as a process that embodied specific approaches and practices, such as assessing need, establishing cause and offering therapy. Many FLs drew from a generic assessment framework informed and guided by both "personal research, background reading" (James) and "common sense" (Luke). It seemed to be an imperative endeavour for FLs to establish cause before attempting to find resolution, even if spiritual approaches were considered appropriate:

"...working and supporting alongside people with mental health issues so it would be a kind of, in terms of how I can best understand and support would be the starting point, if that makes sense." (Tim)

"...prayer is good, but start with the counselling side of it, find out the cause, why is he facing it, what caused the problem, because without finding the cause you cannot find a cure [...] it is a matter of knowing what is the cause of the problem and then you begin to do it from there."
(Musaka)

For a majority of FLs, establishing cause entailed conducting comprehensive, and often, time consuming assessment akin to standardised MH assessment protocols. Although assessments were described as being idiosyncratic, they involved exploring the history of the congregant's problem, causal factors,

ascertaining whether the individual is known to the MHS, linking the person back into the identified system as well as the wider FBO network, signposting and/or “resourcing” (Delroy) them to receive appropriate help, and coming alongside the individual so that they feel supported and cared for:

“One girl we had she had been on medication for sixteen years and she had been in our church for about seven [...] we noticed this really erratic behaviour [...] we managed to find out her health care worker was and contact them and expressed our concern about her[...]. But it was trying to get her to try and seek help either to her GP or back to her health care mental health unit basically. Um and that took, that was a process over a month. And that’s how we tend to work, you know what I mean. Apart from that its community, it’s getting people alongside them...” (James)

“... we've offered [individuals] a range of resources that we've been able to acquire over the years based on a number of community initiatives that we are doing and so give them some resources [...] and with them hash out a plan of how you can get some additional help and support so [...] we guide people through a variety of options to help them to use available resources.” (Delroy)

“We run a project locally that offers access into counselling and again a number of people with mental health issues have adopted that route of going into a place where they can get long term counselling and therapy.” (John)

FLs also described the nuanced process in providing spiritual and religious care. This entailed being empathic, non-judgemental, providing unconditional love and empowering individuals to engender hope. Noticeably, an emphasis on ‘listening’ and ‘love’ seemed to be core processes in the practices and roles of faith leaders when coming alongside congregants experiencing mental health difficulties:

“My response to people who are obviously struggling and obviously uncertain and afraid is to listen to love to pray and I think the fourth thing to keep going not to back off.” (Alfred)

“For me as it stands I’d be there to pray for that person um i would be there to listen... (Luke)

“It’s a mandate you know and at the end of the day we are called to love God and love one another.” (James)

In addition to listening and expressing love to individuals who are in distress, there was the idea of coming alongside, sitting with people or holding people in prayer and notifying them that they are being held - a practice that seemed akin to ‘containing’ and ‘holding’, whereby FLs may act as a container for congregants anxiety so that it becomes tolerable for individuals to manage:

“My first role would be to listen, my second role I think would be to love them whatever they feel about themselves and so on, and my third role, and they are not in layers, is to engage in holding prayers; love for him and we just say we are holding you in prayer” (Alfred)

“It’s the coming alongside, it’s trying to I guess it’s trying to understand you know. It’s what we do you try to empathise with people and try to come alongside them and offer as much help...” (James)

“...some characters come in with severe paranoia and just sort of supporting and listening where they are and that kind of thing [...] I think just coming along side I don’t think we do anything dramatic but um quite often it’s just starting where people are.” (Tim)

For many FLs, coming alongside encompassed a role similar to MH care-coordinators who have a duty to negotiate and coordinate holistic care and well-being of an individual within MHS. For FLs this comprised of pastoral visitations in hospitals and prisons, assisting in the MH act assessments, contributing

towards case meetings and tribunals, offering spiritual advice to MH clinicians, and working alongside the judicial system for individuals who enter the MHS through penal means.

“Quite often we are called into a situation, we had a situation a few years ago where a mum had in effect totally flipped [...] she wouldn’t allow the police or the social services or the doctors in, she was just like refusing and was threatening to kill the kids if they come in. Now we’re brought in to that to go and chat to her, which we did, and we managed to get her kids out and get her into prison [...] It was difficult situation, I had to accompany the woman in an ambulance to the hospital, got her admitted to hospital, I left the hospital then this had gone on from half past ten in the morning and I left the hospital half past 12 in the evening, didn’t have any money, and had to walk my way home because that’s the reality, and they were like ‘fine you can go now ‘ [laughs] and I’m like, ‘Okay, thanks for that, that’s great!’, but that’s the reality, you know , you just help where you can.” (John)

3.1.2.2. “Community: The Constitution Of The Church”

This theme encapsulates the idea of community being a central component of FLs role and approach, which inherently links with ‘coming alongside’ to ameliorate MH difficulties and address wider systemic issues, such as marginalisation and inequitable statutory services. Emphasis was also placed on linking individuals into the community so that they have valued and meaningful roles.

“Community church is part of the constitution of the church that we get very involved in the community.” (Mavis)

“We have a lot of community groups and working with community groups is the whole prevention...” (Susan)

“We then try and do is engage people more into community activities” (Tim)

“People with mental health conditions are normally, have normally isolated themselves because they have not been understood so isolate themselves, they have very few friends, and to me church is about community, living in a community, so we like to get people involved and we like to come alongside people and we do that with everyone so there’s no you know we try not to ostracised people. We are inclusive rather than exclusive.” (James)

The idea of acceptance and belonging seemed to be central to the approaches employed by FLs in connecting people into the FBO community. This may reflect a wider collective narrative of human connectedness, and responsibility for and accountability to one another. For example, being “my brother’s keeper” (Mavis) and, therefore, indebted to be available and supportive to others’ needs, engulfs notions about collective responsibility i.e., no one person is alone in the process of help.

“... it’s all our responsibility the government’s strategy paper on No Health Without Mental Health makes that quite clear it is the nation’s responsibility to actually help wherever they can [...] part of our responsibility irrespective of the government strategy paper said our responsibility is to be our brothers keepers, so we are there to support to hold to nurture...” (Mavis)

“We always endeavour to encourage people to see themselves and recognise themselves as part of the community of God, which in and of itself is the biggest support network, and so it’s not just reliant on any pastor or individual leader, but we help to facilitate the whole network so that there is support for one another...” (Kofe)

The impact of community being constitutional of FBOs influences the practices and approaches utilised by the FLs, which are seemingly guided not only by biblical principles of unconditional love and responsibility, but also the beliefs and explanatory models of MH and religion. FLs taking a more bio-economic-psycho-

social-spiritual stance of MH maybe more likely to recognise social aspects of care that correlate with MH difficulties and address it within their community. For example, many FLs spoke about engaging in activities that gravitated around community participation and needs, such as proving food and clothing banks, running homeless hostels, and facilitating parenting programmes and youth groups.

The focus on social aspects of care in the process of help also highlighted a unique role that FBOs occupy in addressing MH inequalities. In analysing the data, it was apparent that a key feature involved in FBO roles included aspects of community social action and prevention. For many FLs, this involved providing activities that curtailed the occurrence of MH problems and built capacity within the community, in the belief that “prevention is better than cure” (Musaka).

“...some of the GP are brilliant and some are awful, some of them the first thing they do is reach for the prescription, and in fact, at one stage here one of our local churches launched an anti-medication campaign.” (Alfred)

“Raising champions, raising health and wellbeing champions, people who have been skilled up with the knowledge based to be able to go out and help others.” (Mavis)

The idea of collective social action for change seemed to be conveyed as an imperative part of FBO communities in changing service provision:

“We are saying we are creating a voice and a momentum to be able to say in actual fact what you are doing does not meet our needs we don't want you here we don't want this we want that instead and have such a voice and have such an influence that that is what will actually take place um the numbers cannot remain this way with all of the money and with all of this great expertise and things have remained this way.” (Delroy)

A large proportion of the FLs' role and involvement in MH care entailed prevention targeted at the community. However, evidencing the outcome of this

work was discussed as an effortful challenge in dealing with immeasurable outcomes of un-happenings which have direct bearing on resources, sustainability and perceived service provision effectiveness:

“We have a lot of community groups and working with community groups is the whole prevention of mental health issues [...] that is never really measurable, but I would like to think, like, the parents-toddler groups stop episodes of post-natal depression and things like that, and the fact that people come in here daily for their lunch and the kind of in community every day stops them from being at home and isolation, and the problems with that and mental health. So you can’t really measure how much something prevents.” (Susan)

“...we probably have several hundred thousands of beds not being occupied because of the work that faith leaders do, not just in London, but up and down the country, week on week, they are holding and often times they have no preparation but they are holding the line and taking the beating, and they are praying and just believing and just encouraging and just holding the line so that these situations don’t set loose on society, you know, so work is being done, so much more needs to be done but it needs to be supported.” (Delroy)

3.1.3. MHS-FBO Relationship

This superordinate theme coincided with the research question of experiences, views and barriers of collaborative practices. Of the ten faith leaders that participated in the study, nine reported having experienced some degree of contact with the MHS concerning a parishioner. The extent of their contact and involvement varied immensely, with some playing a more direct and active role in collaboration and consultation with MH professionals, and others engaging in more indirect contribution, such as signposting and referring. A majority of FLs reported a positive experience of MHS contact, and spoke about a bi-directional

referral patterns between MHS and FBO. Four FLs spoke about their FBOs having a close relationship with the MHS, which influenced referrals, uptake of training places for health professionals provided by FBO, funding, and support with FBO activities:

“We do placement here for trainee GPS that are training to be doctors and that’s been a good link making sure that they are understanding community needs and vice versa ...” (Tim)

“We are a providers site, so in other words the church’s building is being used by the trust to house, so I run a self-esteem group here and I also see clients face to face for CBT sessions [...] we are hoping that [the] relationship [with MHS] grown even more to incorporate other forms of medical health and [...] have the building the hub of these types of activities...” (Delroy)

A few FLs spoke about feeling respected, valued and recognised as trusted advisor and having the support and investment of MHS. For two FLs this included the opportunity of being trained in a therapeutic model:

“The head of the family therapy unit and some of the other leaders [...] started providing some skills to some faith leaders because [...] they [FLs] are at the forefront, they are on the battlefield, they are dealing with issues for which skilled clinicians need all their skills to manage...” (Delroy)

3.1.3.1. “We Are Part Of The Solution!”

For some FLs there was a perceived lack trust and suspicion from the MHS concerning FBOs. FLs spoke about the need to vindicate themselves as being trustworthy and credible individuals worthy of being consulted with for the purpose of MH care:

“We need to show them that we are not a problem, we are a part of solving the problem instead of creating it even more.” (Musaka)

“... I guess it’s a trust thing you know. The more that we’ve had to the more we’ve spoken to them the more information we seem to get because I think they realise we are actually trying to help them, we are part of the solution not part of the problem [...] so it’s just a matter of just talking with these organisations and I guess letting them know that we just want to support them and we are not trying to take over or that’s the last thing we are trying to do. We want the best for that person, so it’s important that we do work together, that’s why I agreed to see you today because I think it’s a great forum for relationship between the church and you know mental health organisations because it is something that um moving forward from what I’ve seen in the last probably ten years” (James)

The rhetoric of being a part of the problem was interpreted as denoting perceived blame of the FBO by the MHS. For example, the above excerpts suggest that MHS may perceive FBO contribution in MH care as obstructive and controlling, which perhaps reflects more general concerns about how power is negotiated and whether FBOs are perceived as having discordant objectives and hidden agendas in the provision of care, which perhaps in turn leads to feelings of mistrust and suspicion.

The issue of perceived ‘illegitimate’ authority was also identified in these interviews, particularly in relation to FLs’ experience of signposting and referring congregants to statutory MHS, where they faced obstacles in information sharing and confidentiality.

“I appreciate it from a confidentiality point of view but when you are trying to help someone and they are not giving you any information at all it makes it very difficult so yeah a few times I’ve struggled to get through to who I needed to get through to. They did ring me back eventually but if it was a life and death situation you know what I mean. And then I had trouble getting through to the right person [...] I felt it didn’t seemed to be a lot of, what’s the word, collaboration between their different departments. They

couldn't put me through; they had to ring da. And this frustrated me...."

(James)

James' extract also highlights the observed breakdown of collaboration between different departments in the MHS, which acts as another layer of stumbling-blocks for the FL. Other aspects of MHS attitudes and approaches that were discussed by FL included the cultural and spiritual-religious assumptions held by some MH staff and western models and approaches used:

"Just the general bureaucracy not actually I guess it's [x] uses a phrase where BME people are so highly over represented in the mental health system to the point where I guess people look at this no longer see it as a problem [...] some of the feedback that the trust and the officials give they say well you know it's just these you guys are just too hard to reach community and that phrase puts the blame where it's easier to manage because it's nothing to do with me but [X] turns it on its head and give it back to them and says well it's not that we're hard to reach it's just that we are easy to ignore." (Delroy)

3.1.3.2. "Professionalisation Of Laity"

FLs acknowledged a dissonance in being positioned by statutory services as MH providers who should uphold specific standards of care (particularly around risk) and the expectation to perform outwith their ministerial training (for example, knowing what to do when someone is in crisis) .This tension was spoken about as being a "professionalization of laity" who are "ill-equipped" (Luke) in addressing the subject area, so it becomes "easy to do badly and hard to do well" (Tim):

"Professionalisation, [...] so pastors are expected to deal with things, which they aren't trained for, and should they be trained for that? I've seen pastors trying to be professionals in all fields, um I've seen it, I mean obviously you don't get it with all pastors but I can think of a few pastors who are 'I know a bit about this, a bit about that, I know a bit about this, and a bit about that',

but I'm still not equipped to deal with certain things, and that's with recognition that I can pray for someone, but we have a system which can deal with needs that I can't deal with.” (Luke)

“It's meant that for us as minister, seeking to assist people that we're able to, if you like, refer or connect with those who are able to do work with people in a way that we're not capable of by way of lack of training, or lack of insight, or understanding, we haven't been through the training of medical professionals in a way that is fundamental to our ministerial preparation, and so as much as there are certain levels of certain aspects that's not the primary focus...” (Kofe)

All FLs raised the issue of training and spoke about the need for healthy and supportive MHS relations to avoid providing care that is inadequate or only at points of crisis. However, some FLs expressed concerns about prospective collaboration and questioned the issue of power impositions to change the role of FBOs to an organisation governed by statutory rules:

“One of the things with ministers is at what point does it become purely administrative [...] the whole thing with ministers is that they fill in forms, they keep records, at what point does the church become a non-governmental organisation, at what point is the cross over made, and another thing that needs to be borne in mind, anyone can fill in the form anyone can tick the boxes [...] whoever it is suddenly just becoming a statistic, suddenly just becoming a piece of paper that the minister has to deal with ... something else to bear in mind that is it to do with relation, is that relationship and I don't think it is ultimately ticking boxes and filling out bits of paper ...” (Luke)

In Luke's extract the concern of reducing and objectifying individuals to meet targets is denoted by his expression of “statistics”. The fear of intimate collaboration with statutory services leading to the professionalisation and administrative role of FBOs may deter FLs from entering into partnership work

despite the acknowledged need for statutory support and guidance around issues of mental health:

“I would have valued at the start of my ministry someone like you coming to a group of ministers, I mean they'll meet other professionals, they'd meet for example often in this borough the mayor would meet with the professionals [...] we would like to form some form of bridge, and the third thing to make sure you can get people into all the training colleges because they will have training colleges even if there are some extended learning, if you could put people into their to make the links to get through.”
(Alfred)

“I think for me personally it's [the support of MHS] the assurance that we are doing the right thing. I think possibly it's easy to do this kind of work badly and hard to do well, do you know what I mean?” (Tim)

3.1.4. Improving Relations

A recurrent theme identified across the data was the need for improved relations, particularly inter-collaboration within FBOs and intra-collaboration between FBOs and MHS.

3.1.4.1. Intra And Inter-Collaboration

The need for dialogue between the organisations seemed to be crucial in averting crisis from occurring and avoiding FBOs being employed at crisis points.

“Like some sort of forum would be good [...] getting together and actually um finding what the mental health, you know, system requires from us, you know. Because at the moment we are like this, we are working separately, if you like, and when there's a real problem then there's an interaction [...] Yea, crisis point. Why don't we talk before that and find out. We can tell them what we can offer and they can tell us what they can

offer and then, you know, hopefully there's a relationship formed..."

(James)

Similar to other FLs, James spoke about the need for an open forum meeting where both FBO and MHS could come together to establish resources and expectations of each party. Mavis and Delroy also provided a similar accounts but from a position of experience of setting up and facilitating such forums to aid intra-inter collaboration in addressing issues such as language barriers between the FBO and MHS:

"We run the conference every year [...] to coincide with World Mental Health day, [...] and that's bringing agencies workers with the community in hope they will learn how to speak to each other because the community don't necessarily have or understand how they can, they don't understand the language of the mental health trust and the other agencies, the agencies don't understand how do we work, how do we even get to the community in the first place to be able to have those conversations with them [...] because if the problem is in the community you've got to work with the community to address the problem and you've got to allow the community all the knowledge that they have to be able to unearth [the resolution]." (Marvis)

The inter-intra collaboration spoken about illustrates the desire for community resources and expertise to be harnessed as a "solutions" to problems that exist; again, reinforcing the idea of FBOs being part of the solution rather than the problem. Collaboration was conceived by FLs as being a shared learning process involving exchanges of ideas and expertise as opposed MH professionals taking a knowing expert position in teaching and informing FBOs how they ought to function:

"We invited a psychiatrist to speak to us [...] he didn't start off well because he started off by saying 'I'd be here to tell you what you need to know', and somebody corrected him and said 'in actual fact you maybe learn something here', and at the end of the session he did go back and say 'I

have actually learned more than I feel I have given to you', but it was the meeting has given the place for that open hearted dialogue and conversation sharing of ideas and practice." (Delroy)

Improving relations also required clear role definition and boundaries so that expectations could be established:

"We um yeah we also realise we are not medical health professions, so I guess it's defining what our role is when it comes to people with mental health conditions so we um yea we come alongside the person concerned." (James)

In addition to suggesting combined meetings, shared expertise and clarified roles, FLs expressed the need of collaboration that would produce some sort of best practice policy or guidelines for the management and care of religious and spiritual individuals in mental health distress as well as a time funded MHS post in which an individual could dedicate their work to building relationships with the FBO as a link worker between FBO and MHS.

"The things that can hinder the limit to which um professionals maybe prepared to engaged and to actually seek consultation and advice, time, something as basic as that, you know, it almost seems as though there needs to be roles as you would have a prison chaplain or a school chaplain where there some sort of funding directed towards someone's time being able to be secure to that end, and so um I guess that would be time and money working together..." (Kofe)

Intra-collaboration was also an area where FLs identified the need for better communication and partnership working:

"I maybe woefully ignorant but there isn't a central body of you know sort of like the Christian mental health society or anything like that um exist to disseminate to pull and disseminate, and so there are various bodies and it's very much upon the initiative of the local church and the ministers

within the local church that will seek out and pursue understanding and information, and then seek to bring that back into the local church.” (Kofe)

3.2. PART TWO: CLINICAL PSYCHOLOGISTS

All of the CPs described themselves as having a faith or spiritual or religious belief in varying degrees of conviction. For a majority of CPs, clinical training, cultural background and upbringing played a role in how they conceptualized MH. Several CPs made a distinction between definitions of religion and spirituality, and stipulated a preference for the term 'faith' due to it being an all-encompassing term without the values and connotations associated with 'religion'.

3.2.1. Making Sense Of Religion And Spirituality In The Context Of Mental Health

This superordinate theme related to the study's research question: 'what are the attitudes and beliefs of CPs regarding MH and religion and spirituality?' Two subordinate themes were developed from CPs' account of their views and attitudes concerning the relationship between religion, spirituality and MH which are as follows:

3.2.1.1. "Religion And Spirituality Is A Part of our life"

Most CPs described MH problems as a result of stressful life events. There was also a shared view of religion and spirituality being an inherent part of life and, therefore, relevant to MH.

"I think there can be a really strong links for some people, especially if we are talking about spirituality [...] it's very relevant to our wellbeing in mental health, religion." (Karim)

"We all have mental health because we wouldn't be human so, so I see spirituality, religion, faith beliefs, as in, as a part of life in the same way that religion and spirituality is a part of people's lives and that mental health. I

suppose, more specifically, mental health difficulties or problems kind of come when there's some sort of conflict or stress that's preventing someone from living their life in the way that they want.” (Sebastian)

3.2.1.2. Religion As A Resource

The nature of the relationship between religion, spirituality and MH was widely spoken about as being a resource for individuals to draw on for strength, support and encouragement:

“Radical change in our life adjustment that would cause quite a lot, they turn or rely on their religious beliefs or strengths, support, or sometimes the contrary, or usually they look to religious content or religious beliefs to help them through the situation.” (Jonny)

“I think they are linked in terms of faith can be, I think, it can be so helpful in terms of like families that I’ve worked with that find their inner strength or part of what contributes towards their inner strength and it comes a lot from, I don’t know, if it’s necessarily religion, but it’s definitely from sort of that the faith or community that sort of comes with maybe being part of being with a religion.” (Malikah)

The potential for religion and/or spirituality to have an adverse effect on MH was not spoken about explicitly in the interviews, which may have been due to CPs not wanting to give impetus to historic assumptions and discourses that problematise belief systems and/or portray CPs as impious and/or insensitive to religious/spiritual philosophies. Ideas about the adverse effects of religious convictions can be controversial and sensitive due to dominant discourses around risk and fundamental religious convictions, which may have been a level of embedded context that CPs acted out for concern of making value judgments.

3.2.2. Faith Talk

This superordinate theme encompassed CPs' approaches, fears and anxieties concerning their role and involvement with service-users' religious and spiritual beliefs and issues. CPs described a large component of their work and involvement as providing safe spaces for service-users to talk about faith. Another role was to assist staff in feeling safe enough to talk about faith whether in the context of contributing to case discussions from positions that drew on their own faith and/or spiritual/religious knowledge base or to help staff initiate faith talk with service-users.

Several CPs reported either personally experiencing a fear/anxiety of faith talk or noticing a fear of faith talk within their service. CPs described this as leading to a culture of censorship, whereby staff eschew opportunities of sharing their religious and spiritual knowledge in case discussions/formulations due to a fear of their beliefs being appraised as inane and unmedical. This fear seemed to be talked about in the way that illustrated the existence of a secular- sacred divide within MHS, which perhaps shapes staff perception of what should and should not be shared, which in turn impacts what sort of knowledge and experience is privileged in MHS.

"Luckily we've got people in our team who are quite well versed within different faiths so they able to lend their own but they're quite anxious about it" (Karim)

"I think the ward team's fear is that people could be labelled believing things that aren't, you know, it's not a medical religion, is not really seen as the medical sphere and if you're working on a ward a lot of staff keep that down and I think um I think coming in with that idea that it's okay to believe what you want to believe, I just want to hear what you have to say and I think that serves to sort of function" (Sebastian)

3.2.2.1. Being Led

Being led in initiating faith talk was identified as a subordinate theme of faith talk, encapsulating CPs' roles and experiences when addressing religious and spiritual issues. In addition to MHS' fear of faith talk, were CPs' own concerns of initiating or conversing about religious or spiritual issues. These concerns seemed to be linked to feelings of unsafe and/or uncertain about the unknown aspects of engaging in faith talk and how to best support individuals seeking psychological help. Concerns about CPs initiating faith talk was also understood as being linked to CPs thoughts about how they might be perceived in the mind of others and whether their own beliefs would be scrutinise and questioned:

"I don't tend to go about talking about it unless people ask me explicit questions... when they do ask me I still feel a sense of oh god they are asking me what am I going to say right how are they going to perceive what I am going to say" (Karim)

There were also contrasting views about the relevance and frequency of faith talk, which was interpreted as dependant on service context, as it appeared that CPs were strongly led by service structures and protocols. For example, Farah and Karim both spoke about initiating faith talk as a routine part of the assessment process within the context of their service.

"...especially in this setting forensic mental health setting it's more of a practice that people will allow me to talk about so they pray or they like going to church and things." (Farah)

"It's routine within the service but often within the service it's do they have spiritual beliefs yes no what are they it's xyz." (Karim)

Whereas in Jonny's service faith, spiritual and religious issues are esteemed as less relevant and factors which were not routinely addressed:

“For the most part it [spirituality and religion] tends not to play a role.... and so some of the religious specific religious content is not ordinary topic [of] discussion or interaction or concern actually” (Jonny).

However, irrespective of faith talk fear, CPs emphasised the need to create openings and spaces of permission for service-users to raise faith related issues within therapy, which was framed as being led by the service-user. However, this may also place onus on service-users to raise the topic, and although CPs expressed the need to create spaces and permission to enable faith talk, issues of power come into mind when considering responsibility.

“With spirituality, if they're talking, if they introduce the topic of spirituality, then I'd follow.” (Karim)

“...generally people assume not to raise it [religious and/or spiritual issues] in psychology session because of the assumptions they might come with about what's okay to talk about and not...” (Farah)

The ‘assumptions’ that Farah discusses in the above excerpt suggest that service-users may not raise issues relating to religion and spirituality, perhaps due to the perceptions of therapy being an illegitimate space for spiritual and religious concerns to be shared, which may lead to a pattern of unspoken and unexplored within therapy, where spiritual and religious issues might become evaded or overlooked by both CPs and service-users. However, despite being led by service users, CPs did engage in faith talk as well as describing some of the approaches utilised in therapy, e.g. the inclusion of sacred text as part of therapy:

“He used the bible a lot to sort of justify why he should or shouldn't feel these ways, so it gave us, you know, it gave us a way of exploring and talking about his problems that might have been difficult if it weren't otherwise” (Sebastian)

“I will open up those doors a little bit those conversations [about religion and spirituality] and um well rather than necessarily staying to a rigidly, ‘you should be working this way and formulating in a particular approach’...”
(Malikah)

3.2.3. Partnering with FBO

This superordinate theme correlated with the research study’s question concerning CPs ‘views experiences and attitudes of FBO and MHS collaborative work’. Of the five psychologists, three reported experience of working or having had contact with a FBO regarding MH care; of these, two were currently engaged in collaborative practices with FLs from different religious sects and denomination that were embedded in their service as paid NHS employees. Their work together involved consultation on care and management (e.g., helping to make sense of religious expression and language) of service- users. CPs also reported referring and signposting service-users to FLs.

A majority of CPs spoke about the desire to work with FBOs due to the perceived benefits but acknowledged that both ‘internal and external barriers’ restricted this from occurring. CPs suggested various ways of overcoming these barriers, illustrated in the subordinate theme: ‘ways forward’. The experience of partnering with FBOs was spoken about as a process that enhanced cultural and religious-sensitive services. Partnership was also experienced as assisting CPs in differentiating religious and spiritual expressions from what is construed as MH problems:

“I regularly meet with the spiritual team um and they are a wonderful group and it's really helpful to both side because they can talk to me about what would be expected of, you know, kinda, what could be done so if someone I didn't have much understanding other than my experience of working here, sort of working [with] people from Muslim background, and what would be offered to someone who, so, for example, if someone comes forward and says they are possessed and the spirit keeps

controlling them and they're scared of this, what would be the way that the imam or whatever would work with this person ... “ (Sebastian)

Views and attitudes concerning partnership work varied across interviews. A majority of CPs spoke about the need for further collaborative work with FBOs, with one in particular taking a clear position about the importance of this work in helping address stigma and shame.

“I was thinking about my civic responsibilities so to speak my responsibilities within the community and particularly if I’m going to start helping people to try and acknowledge about mental health not just distress but across all of how to be mentally healthy [...], then thinking okay how can we make it engaging that reduces the idea of stigma around it.” (Karim)

In addition, greater collaboration with FBOs was viewed as an opportunity to build capacity in spiritual approaches and awareness:

“I think it will give me a different, yeah, more experience of actually what spiritual approach would look like...” (Sebastian)

3.2.3.1. Internal And External Barriers

This subordinate theme refers to barriers that reside external to CPs, such as funding constraints that restrict collaborative practices from occurring, and internal to CPs, such as those which hinder recognition of opportunities of collaboration. Crucially, if needs are unspoken, then opportunities of spiritual, religious, faith-based work go unexplored; again highlighting the issue of responsibility discussed in ‘Faith Talk’:

“Maybe that’s another barrier actually, that unless explicitly talked about as a need I might not be thinking, it might not occur to me as much as I’d like, um, I don’t know if that’s an internal barrier. I suppose there’s a lot of other things to consider, risk, and you know, communicating to the various parties that need to communicate and stuff, referrals and who’s going to

see them and possibly, actually, possibly, definitely, the sort of spiritual side of faith leaders, faith leaders and stuff might get missed in that kind of thinking process...” (Sebastian)

In addition, there were external barriers, which related mainly to service context. For example, service commissioning objectives and policy implementation guides were spoken about as being determining factors as to whether CPs engaged in collaborative FBO work and interagency liaison, which is in fact central to CPs’ role. It seemed that external top-down processes had the most impact on how collaboration was constructed and whether the culture of the service considered it relevant to their overall service aims, which perhaps strengthen internal barriers that inform and shape attitudes and beliefs concerning the relevance of partnership work. The issue of austerity and the economic climate of the NHS were also considered as influential drivers shaping barriers in partnership work:

“I’m not sure whether either whether the NHS has the scope, dare I say, inclination, at the moment given the structures, you know , it's not just about staff on the ground doing the work, it's about the target and budget and the cost efficiency, it's always there, and the cuts in the staff and so, you know , there's a lot of pressure that it's hard to then take an approach where we are just going to open because we people can't afford to be” (Farah)

“One of the biggest problems is time for clinicians, no time for the team, it sounds like a crude excuse but often it's the first thing to go building links with community organisations, unless it's explicitly stated in your commissioning document, it's the first thing to go and I've we've tried to make steps with schools and FBOs “(Karim)

Practical aspects of collaboration, such as accessibility and communication were also discussed as being illustrative of external barriers of FBO partnership:

“If you've wanted to talk to [FBOs] accessibility is probably the main problem that they are only around certain days of the week and they're not

they are not part of the team, in the sense that they are not on email list. Quicker communication is not so not as easy with them but here they are so open to um I mean I think I've got contact for most of them their own emails so I can do that quite quickly just to say 'I need to have a chat with you'" (Sebastian)

3.2.3.2. Ways Forward

This subtheme captures ideas of overcoming the barriers aforementioned in a way that can move FBO partnership work forward.

Several psychologist spoke about the need to take a not-knowing non-expert curious position within their practice to help facilitate partnership work. The idea of 'losing' psychology, or at least the 'expert' position of the psychology profession and professionals, seemed a key concept for moving forward, which suggests the need for critical reflection concerning the power, assumptions and approaches held within psychology.

"I'd argue that we would have to lose the psychology or the formulised psychology and we'd have to go to being people who are a lot more understanding ,and in that sense we'd have to rely on our Rogerian stuff of just listening and being there for someone [...] thinking about it and being open to learning about faith-based model, it's that I don't think we do that at all right, I don't think we do that at all, and because we don't do that I think the problem is we fall at not knowing. I think as a profession, if we stopped thinking we know and we started thinking we don't know we would start to get there a lot easier." (Karim)

In addition, there was the idea of needing channels of communication between MHS and FBO whether in the form of time-funded roles tasked at building community links and bridging gaps in communication or a core group of people acting as a steering group. Accessibility of FBOs and FLs was also discussed as factors that could facilitate collaboration:

“I’d say you’d have a steering group of lots of different professionals and people just who aren’t religious or not different belief systems to come together and think about it as a project that would be in an ideal world to take it forward so yes I’m all for it” (Farah)

“...you need a little working group of people that are able to start those conversations and be thinking together maybe not necessarily about individual cases but just already get those links in place so it means that when you do have a particular issue with a particular family it means you have a channel an avenue to know how to mainly get advice to start to address it I think that’s what’s good with the dove organisation they have they’ve employed someone who is a religious leader who is their job to go out and make friends so to speak with other religious leaders.” (Malikah)

4. CHAPTER FOUR: DISCUSSION

This chapter provides a summary of the findings that emerged from the analysis and then discusses them in relation to the study's research questions/aims and the wider literature. The discussion then moves towards a critical review and evaluation. The chapter concludes with clinical, teaching, service, and policy implications of the study.

4.1. Summary of Results

This study was undertaken in an attempt to understand and explore the views and conceptualisations of London-based FLs and UK CPs regarding MH, religion and spirituality. It also sought to explore the role and extent of FLs and CPs involvement in MH care with someone with spiritual/religious beliefs, and the experiences and views of FLs and CPs concerning FBO-MHS collaborative work.

4.1.1. Attitudes, Beliefs And Explanatory Models

Both FLs and CPs drew from explanatory models of understanding MH, religion and spirituality that identified stress, conflict and bio-psycho-social conceptions of MH. Additionally, FLs spoke about MH being synonymous with physical health and along a continuum, whereas CPs spoke explicitly about the benefits of faith, religion and spirituality as a resource that buffers in times of distress. FLs discussed conceptualisations of MH as being either a preferred belief or un-preferred belief, with the latter applying to 'purely spiritual and mystical' ideas of MH. Preferred beliefs were identified as bio-psycho-social-spiritual explanations of MH and MH along a dimensional-spectrum.

4.1.2. Role And Extent Of Involvement In MH Care

CPs and FLs role and involvement in MH care of religious and/or spiritual individuals overlapped, particularly in relation to therapeutic processes and conversations, such as 'coming alongside' individuals to support and create spaces to talk about their difficulties. FLs described a process of assessment

which emulated assessments conducted by CPs in MHS. FLs involvement in the process of help was reported as being guided by common sense, personal background reading and biblical principles.

CPs spoke about fear of initiating conversations concerning faith, religion and spirituality, which was captured as part of the superordinate theme 'faith talk'. Despite reservations of initiating faith talk, CPs reported a clinical duty to provide openings and spaces for service-users to raise issues of faith, which were often led by service context or the service-users. For CPs who engaged in faith talk as part of therapy, their approaches included use of sacred scripture to scaffold therapeutic conversations.

CPs role extended beyond 1:1 therapeutic work with service-users and involved building confidence among staff to engage and initiate faith talk for the purpose of case discussions and 1:1 clinical work. Service context and culture were identified as drivers that shaped the occurrence and frequency of faith talk, as illustrated in the subtheme 'being led'. FLs involvement in MH was multifaceted, with a majority of FLs referring to community work and prevention as an integral role of FBOs. FLs expressed concern regarding their sustainability, which was linked with the lack of measures in place to evidence their worth and work. This also had financial, support and resource implications.

4.1.3. Views and Experience of FBO-MHS Collaboration

In regards to collaborative practices and the relationship between FBO and MHS, FLs talked about their experience in a way that was interpreted as perceived blame and mistrust from MHS towards FBO (e.g., feeling as though they were positioned as "part of the problem rather than the solution"). The issue of legitimate authority and perceived worth was identified as being experienced by FLs, particularly in the process of help when attempting to refer congregants to MHS.

CPs reported referring and signposting service-users to FLs, and being engaged with internal NHS chaplains, with whom they consulted and discussed cases with to aid formulation and MH care. FLs views concerning FBO-MHS collaboration

were diverse, with all welcoming the idea and expressing the need for collaborative work. However, for some, the issue of collaboration raised concerns about power, control and change in relation to their role and function as FBOs. This was captured as the ‘professionalisation of laity’, which reflected FLs feeling ill-prepared and ill-equipped to work outside their ministerial training.

The expectation to function as frontline MH staff raised concerns among some FLs that their job is being “easy to do badly hard to do well”, particularly with insufficient support and inadequate resources. Concerns of professionalising FLs also incorporated concerns of increased paper work and a marring of roles, which would position FBOs as governmental organisations with entailed expectations inherent of statutory MH care. A superordinate theme, ‘MHS-FBO relationship’, captured the experiences and views of FLs working with MHS. For several FLs their experience of collaboration was positive and involved innovative ways of working, including: FBO junior doctor placements, provision of Improving Access to Psychological Therapies (IAPT) within FBO setting, and joint MHS-FBO community activities and conferences.

CPs views and experiences regarding collaboration differed to FLs, and again, related to service context and constraints, which determined the relevance and likelihood of collaboration. However, for some CPs there were ‘internal barriers’ hindering them from collaborative practices, for instance, if the need for interagency work with FBO is not spoken about explicitly, then opportunities for collaboration are unexplored or missed. However, both CPs and FLs spoke positively about the need for collaborative work and talked about ways to move their relationship forward. For example, the need for time funded role, an open attitude of mutual learning, and a respect for each other’s’ expertise. FLs also talked about the need for inter-intra collaboration that could open up dialogue, good practice and information sharing within and between organisations.

A discussion of some of the themes and subthemes outlined above are expounded further in the following section and are discussed in relation to the research question and wider literature.

4.2. Discussion

4.2.1. Views And Beliefs About The Relationship Between MH And Religion And Spirituality

Previous research points to disparities between CPs and the general population concerning religious and spiritual beliefs (cf., Smiley, 2001; Delaney, Miller & Bisono, 2007). However, unlike previous findings, CPs in the present study all professed a faith, religion or spiritual belief, which may account for CPs' views of there being a positive relationship between MH and religion (e.g., religion and spirituality acting as a resource and buffer for individuals in distress). Moreover, it could be argued that CPs who have religious and spiritual convictions maybe more inclined to talk about religion, spirituality and MH in a way that positively frames the impact of religion on MH. This in turn could also account for the absence of talk about possible adverse effects of religion on MH. In regards to FLs, all spoke about holding psychological, western medical views of MH, which were associated with natural causes, social, biological, spiritual and economic determinants. These explanations correlated with the bio-psycho-social model of MH (Engel, 1997), and similar to FLs, CPs also held beliefs and views that were compatible with FLs conceptualisations of MH, which undermines previous findings and arguments of there being discord and scepticism between psy-professions and FLs beliefs of MH aetiology (Lipsedge & Littlewood, 2005; Ahmed & Webb-Johnson, 2008; Wood et al., 2011).

For a majority of CPs, clinical training, cultural background and upbringing played a role in how they conceptualized MH; whereas for FLs, background research and experience of MH as a common occurrence within FBOs informed their beliefs and views of MH, which in turn were influenced by secular biomedical and psychological concepts of MH and dominant medical model discourses. Personal experiences and relationships with mental health, religion, and spirituality may also influence the lenses through which both CPs and FLs view and understand the relationship between MH, religion and spirituality, which in turn, shape the discourses they use to talk about MH, religion and spirituality. For example, a majority of FLs spoke about personal experience of MH problems, either within

their immediate family or concerning themselves, that had resulted in contact with MHS. These exchanges may have reinforced scientific and social-political discourses in non-religious contexts (Leavey, 2010). Leavey (2010) argues that mainstream western beliefs of MH problems are increasingly informed through the professional middle-class, educated and sceptical of anything resembling the superstitious, and therefore, “sin, witchcraft and demonic possession are often consigned by FLs to a bygone dispensation” (p. 584).

The findings of the present study were consistent with Leavey’s (2010) study of beliefs among Christian clergy, whereby some clergy reported sitting more comfortably with bio-psycho-social explanatory models of MH than with those bound in demonic and supernatural interpretations. However, the novel findings in the present study highlight a compatibility and complementary aspect of FLs conceptualisations that map onto psychological explanations of MH. The implications of FLs holding more westernised psych-professions’ ideologies could mean that FLs’ conceptualisations of MH, as illustrated in the finding, become a shared discourse with FLs being able to hold a ‘both/and position’ (Andersen, 1992) where they understand the importance of science but also of religion/spirituality, which affords them the possibility of seeing themselves as having a role in relation to MH of their congregants.

According to Leavey (2010) an explanation of this could be owed to the modernity, exemplified by urbanisation, technological solutions and specialist diversification which can diminish the need for shared religious values and beliefs. It could also be argued that rational, bureaucratic processes, science, and scientific thoughts leave little space for supernatural aetiology; with mainstream Christianity leaning more towards de-sacralisation and anti-magicalism (Wilson 1973), and though, whilst prayer and faith in God continues to be endorsed, the negative supernaturalisms of demons, magic and witchcraft have, to a larger extent, relinquished from social reality and public discourses (Leavey, 2010). It seems that such convictions lack open public expression, and are ushered into the private, where the acceptance and attachment of the supernatural, sacred and spiritual can be expressed. This, in part, may be due to the impress of wider discourses around risk and legal penalties that over the past

14 years have come to the fore in public attention, with highly publicised cases (e.g., Victoria Climbe case) in which supernatural beliefs led to unethical practices and homicides.

4.2.2. The Role And Extent Of Involvement In MH Care Of Clients Or Congregants With MH And Religious/Spiritual Beliefs And/Or Issues

There is no doubt that FLs occupy a role as front line MH workers, however, the legitimacy of this role, the lack of support and situational constraints, mean that they are often faced with tasks outside of their ministerial training. Feeling ill-prepared and ill-equipped in dealing with some of the difficulties they face day to day with congregants illustrates the degree to which support and guidance is needed from MHS. The idea of “easy to do badly and hard to do well” (Tim) corroborates findings over 10 years, in which FLs roles were under-recognised by training bodies and central organisations that prepared them for ministry, causing them to feel unconfident about issues relating to MH (cf., Wood et al. 2011; Leavey, 2007). More training and support was highlighted by most FLs, and was spoken about in a way that facilitated shared learning for both FLs and MHS, with psy-professionals taking a more appreciative curiosity and openness to learn from rather than teach FLs. This was a point also raised by CPs, who discussed the need for the CP profession to de-centre and lose formularised psychology so that there is an openness to mutually learn and share.

Both CPs and FLs spoke about approaches that incorporated the use of sacred text and the need to be present with an individual in distress, which are novel findings to the existing literature. Faith that complements and not conflict was also demonstrated in the approaches taken by FLs in the process of help; and although guided by religious principles and frameworks, core processes were more similar than different to psy-informed approaches. For instance, Rogerian concepts of empathy, active listening, and unconditional positive regard were clinical processes that FLs seem to naturally engaged with, and were notably the same approaches that CPs advocated for as pivoting their clinical work.

CPs' role and involvement in MH care of individuals with spiritual or religious issues were principally tied to therapeutic 1:1 clinical work, as captured under

‘faith talk’. Initiating faith talk seemed to be predicated on a number of factors, particularly service context and culture, although a professional discourses regarding professional identity may have also influenced initiating faith talk. For example, people can subscribe to a particular discourse around religion or MH, which promulgates certain definition about which persons, or what topics are important or legitimate (Hoffman, 1992). Therefore, it could be argued that clinical psychology discourses around standards and professional conduct (HCPC, 2007, 2012; BPS, 2009) may have, in addition to service context, also influenced CPs reservation and uncertainties of initiating faith talk, and to some extent, influenced the absence of talk about adverse effects of religion on MH. CP professional discourse may contribute to personal and professional dilemma, in which CPs struggle to negotiate the boundaries of each identity in clinical settings. These boundaries can be blurred by professional governing bodies that outline conduct that impinge on a CPs personal identity and expression. Such stipulation of codes of conduct can become internalised discourses of moral codes of right and wrongs, which in turn may influence clinical decisions about what ‘should’ or ‘should not’ be discussed in clinical settings.

For example, the blurring of personal and professional identities is epitomised in the BPS (2013) *E-Professionalism: Guidance on The Use of Social Media* pertaining to personal material transmitted in public spheres, and also demonstrated in the HCPC (2007) *Standard of Conduct, Performance and Ethics*, which stipulate: “You must keep high standards of personal conduct, as well as professional conduct. You must not do anything that may affect someone’s treatment by, or confidence in, you” and “You must not get involved in any behaviour or activity which is likely to damage your profession’s reputation or undermine public confidence in your profession” (pp. 7-13). These codes of conduct are also reflected in the HCPC (2012) *Standards of Psychologists’ Proficiency*.

The *BPS Code of Ethics and conduct* (2009) also state that psychologists should “avoid personal and professional misconduct that might bring the Society or the reputation of the profession into disrepute”. Such standards are not only restrictive but also ambiguous and can lead to a perpetual fear of how CPs ought

to negotiate their personal and professional identities, which can be problematic if personal identities exemplify what society perceives as more fringe and/or extreme religious convictions. In the context of professional discourses, it can be assumed that there is an idealised image of CPs being neutral, apolitical, and atheist (Fox, Prilleltensky & Austin, 2009; Prilleltensky & Nelson, 1997), therefore to deviate away from such standards may feel unsafe and unprofessional, particularly where the views and beliefs are seen to be unscientific and unmedical in an environment where medicine and objectivity are privileged as providing absolute truths about reality.

For example, the analysis of CPs data revealed fear around raising matters of faith in the clinical setting due to concerns of it being an illegitimate, “unmedical” (Sebastian) or unprofessional-enough topic for the medical-clinical milieu and, therefore, abdicate and censor religious-based knowledge. These findings were consistent with Dura-Vila et al.’s (2011) study pointing out psychiatrists’ concerns that they might be appraised by colleagues and supervisors as “anti-modern”, “unscientific” and “unprofessional”, and therefore censored their own religious beliefs and practices within the medical setting.

For some CPs, initiating faith talk meant being led by the service-user to raise issues of spirituality and religion, using their expertise to open up space to allow new meaning to emerge, thus gravitating towards a position of safe uncertainty (Mason, 1993), which would engender cultural and spiritual humility (Whitely, 2012) for service-users to talk about issues of faith. However, this places responsibility with the service-user, when CPs should voice the unvoiced and invisible (Burnham, 2012). If CPs do “not think about things, they do not see them”, leading to an “out of mind, out of sight” (idem, p. 153) phenomenon, therefore voicing the unvoiced by punctuating it in the conversation may contribute to transparency that is therapeutic at best or an unhelpful exposure at worse (idem). This in turn, results in a clinical dilemma for CPs, particularly when there may be more that is unvoiced by the service-user, than voiced; making it difficult for CPs to know what is relevant, necessary, appropriate or of therapeutic potential to voice.

The ability for CPs to notice what is invisible generates curiosity and invites service-users into a spoken domain where issues of faith can be discussed. However, this involves taking relational risks in conversations (ibid), such as taking up the positions of power and responsibility by verbalising the unspoken and tentatively enquiring about faith so that openings and openness come to the fore without shame and stigma, or the presumptions of faith being an off-topic area for therapeutic conversations. Such relational risks should complement a not-knowing stance, which entails taking a "general attitude or stance in which actions communicate an abundant, genuine curiosity" (Anderson & Goolishian, 1992, p. 29), where CPs position themselves as being informed by the service-users instead of preconceived opinions or expectations (idem).

Despite CPs talking about their uncertainties of initiating faith talk, a majority went beyond fear and engaged in faith talk to embed it in therapy, using service protocols to inquire about issues of spirituality and religion - requisite of clinical assessment. In terms of FLs role and involvement in MH care, a core aspect of their role pertained to the facilitation of opportunities for solidarity within the FBO, which took the form of community being the constitution of the church. This was analogous to 'Communitas' (Denborough, 2008), and a concept that echoed Freire's notion of 'the intervention of unity in diversity' (1994, p. 57). Communitas is a sense of shared unity among individuals who are going through a similar experience, where they see each other and their role in the world unencumbered by their history (Denborough, 2008). FBOs emphasis on community may also be understood as an embodiment of 'Ubuntu', a concept that speaks about community rather than individualism (Ngubane, 1979; Gade, 2011), thus, corroborating previous findings that highlight FLs' approaches as communitarian and inclusionist (e.g., Leavey, 2008).

The Ubuntu and communitas aspect of FLs' involvement in MH care encapsulates social action: a 'coming together' to form a group or movement for progressive change for individuals who maybe struggling alone or easily ignored. It could be argued that this type of MH involvement mimics liberation psychology principles that rest on the premise of dismantling social inequities and exclusion by "giving voice to the politically and culturally silenced" (Montiel & Rodriguez,

2009, p. 155). FLs role also involved challenging inequitable services and practices to provide change in social systems that are perceived harmful, for instance, forming “anti-medication campaigns” (Alfred). Their emphasis on MH promotion, prevention and early intervention represents work achieved at all levels of prevention; from primary, with the provision of parenting groups, through to tertiary with FLs working upstream to influence policy-makers and commissioners, which resembles CPs multifaceted role in MH care (e.g., Prilleltensky and Nelson’s (2002) outline of CPs’ role and approaches to MH prevention).

FLs described the crux of their role being community-oriented and community-informed, which was consistent with previous literature that highlights social aspects of FBOs and the important role that they have played in the deinstitutionalisation of MHS to community (e.g., Friedli, 2000; VandeCreek et al., 1998; Merchant & Wilson, 2010). However, the need to address social exclusion and provide a sense of belonging, that is “inclusive rather than exclusive” (James), and what can be understood from a psychological framework as ‘containment’ (Winnicott, 1971) in the community suggests an emphasis on socially valued roles which address devaluation, stigma, community participation, and increasing competence.

4.2.3. Experiences And Views Of Collaborative Working Between FBOs And MHS

FLs and CPs differed around collaborative working, with CPs experiences and views being strongly dictated by service context, policies and commissioning statements, whereas FLs experiences and views were shaped by the type of relationship they had with their local Trust. Some FLs reported having good working relationships with their Trust, which influenced the recognition of FLs’ role and need for support and clinical skills. For example, two FLs reported receiving systemic training, which demonstrates the acknowledgement and value of FBO contribution in MH care. Although it is important to note that this was not the experience of all FLs. These results challenge previous findings of there being a high level of scepticism among MH professionals (Needleman & King, 1993) and suggest a shift in attitude within MHS towards appreciation rather than

scepticism. Additionally, the result provided new evidence elucidating FLs' experience of collaborative practices and contact with MHS and professionals as positive (cf., Wood et al., 2011).

The shift in perceptions and assumptions concerning FBOs may account for the reported bidirectional referral pattern between FBO and MHS. Both CPs and FLs reported either having experience of referring or being willing to refer to respective organisations, where appropriate. These findings contradict current literature that has consistently found a unidirectional referral pattern of FBO-MHS. Therefore, it could be argued that the attitudes held by FBOs concerning the secular-sacred divide are diminishing. Indeed, for a majority of FLs, faith complemented rather than conflicted with MH care, which perhaps accounts for the openness and willingness to refer and support congregants receive secular forms of therapy (e.g., CBT) as well as endorse help-seeking behaviour that embraces medical intervention. These findings do not support previous research which asserts a pedagogical approach taken by FLs due to their concern of talking therapy being either antithetical to religion or at odds with religious beliefs (cf., Leavey, 2008).

Some FLs argued that in order to move collaborative practices forward with FBOs, CPs would need to dismantle the psy-expert position and de-centre psychology's attention from its own scientific status, to devote itself to the urgent problems of the oppressed majorities (Montero & Sonn, 2009). Interestingly, several CPs also made reference to a teaching-expert position in collaborative work, and spoke about the need for CPs to take a not-knowing position whereby FBOs are the experts with knowledge and untapped resources warranting recognition and appreciation. Similarly, FLs' conversation concerning moving forward related to the need for "open" "healthy" (Kofe) discussions with MHS.

Dismantling or "losing formulised psychology" (Karim) may also speak of an emancipating process of CPs' response to perceived constraints placed on their role and profession. Perhaps by liberating CPs from formalised psychology, CPs may be better positioned to forge alliances and relationships with community based projects and organisations, thus promoting interagency work, which is an

essential part of their role and an aspect of work that CPs commented on as moving forward in FBO-MHS collaboration. This aspect of CPs role was spoken about by FLs who discussed their expectation of collaborative interagency work, whereby MH clinicians go into the community to forge relationships and help community tap into community resources. Martín-Baró (1998) poses a similar argument by stating that “It shouldn’t be theories that define the problems of our situation, but rather the problems that demand, and so to speak, select, their own theorizations” (p. 314). Therefore, it could be argued necessary to de-ideologize reality to peel off the layers of ideology that individualise, and pathologises, thus liberating psychology from psychology. This divorce of psychology from itself assumes a critical commitment that gives back to the people the knowledge they have gained of their reality (Burton & Kagan, 2005; Martín-Baró, 1994).

Another point raised in the analysis concerning experience and views of collaboration related to laity being professionalised beyond the support and training required. The concerns of doing the job badly were illustrated in the results, with references made to taking a purely spiritual approach that has legal and ethical implications. However, the apprehension of loss of power and control over the role and functioning of FBO could lead FLs to withdraw or become sceptical of collaborative practice, particularly where there are no clear demarcations distinguishing FBO as NGO and not governmental organisation. Further, a fundamental concern about loss of service-user care and love if collaborative practices occur between FBO and MHS was expressed by FLs, who described being disconcerted by the prospect of parishioners being transformed into statistics and engagement, with congregants being converted into tick-box exercises that are immersed in an NHS culture of targets and outcomes.

4.3. Critical Review

The current study has provided new findings as well as producing findings which have both challenged and supported the existing literature. However, there are limitations to the study, as qualitative research can create challenges, as researchers cannot be objective narrators even in describing others accounts; nor can it be possible to write without an implicit or explicit desire to convince the reader of a particular point of view; for to read critically is to rewrite (Freire, 1973). Therefore, through reflexivity, a key factor of qualitative research, these challenges and limitations are considered.

4.3.1. Issues Of Reflexivity And Limitations of Research

4.3.1.1. *Christian Trainee CP*: Being mindful of my position as a Trainee CP representing statutory MHS, I was cognisant of FLs relationship to help with MHS and possible instances of scrutiny that may have befallen them during contact with MHS who can be incredulous to FBO contribution in MH care (e.g., Wood et al., 2011; DRE, 2005; Leavey et al, 2007; Koenig, 1998). This was a constant reminder for me, as a majority of FLs were inquisitive about my role and interest in the subject area, which led to me to wonder whether responses provided to the research questions were influenced by my position as a trainee CP and my admission of Christian faith and affiliation. These two positions may have inadvertently provided and/or created a context for social desirability to occur, whereby FLs disclose views that are perceived to be in-line with my philosophies. Furthermore, the similarities between myself and the FLs may have foreclosed some of the discussion that could have occurred had I not had previous personal knowledge and experience. However, sharing a Christian faith also provided a similarity with the FL participant group, which may have led to creating a safe space for open discussion, in which participants felt more at ease with someone perceived to be similar to them.

I had also wondered whether my experience and assumptions concerning some Christian practices towards mental health, as discussed in Chapter 2, may have privileged some conversations more so than others and thus drawn my attention

to aspects that were unfamiliar to me, thus impacting my level of curiosity and the follow-up questions, or 'topic questions aimed at inducing narratives' that I asked the participants. The interviewer-interviewee power relationship was also a dynamic that influenced the data collection process. However, attempts had been made to address power difference in this relationship by strategically re-positioning the 'interviewer-participant' role to 'narrator-listener' role to foster an emphatic rapport that facilitated engagement rather than distance for participants. I anticipated that by adapting to an informal style when greeting participants it would have potentially reduced barriers as well as place emphasis on the interviewees as experts of their knowledge, experience and roles, and my role as listening to what they had to share, thus enabling me to remain curious (Willigs, 2013).

Additionally, my position as Trainee CP interviewing CP reminded me of the professional discourse around conduct, ethics and practice and how this may have influenced CPs' responses, rapport and engagement with the research. CPs knowledge and experience of the doctoral process, knowing that their responses would be recorded and scrutinised under the process of qualitative analysis, added another layer of influence in which CPs may have acted out of in response to the research questions posed. Furthermore, my position as a Trainee Clinical Psychologist studying at institution whose ethos is closely aligned to taking a critical stance appeared to have influenced and shaped the theories and literature drawn from when interpreting and analysing the data. Ideas akin to more postmodernist were ideas that were very much at the fore when thinking about discourses and the context in which participants may have acted out of when discussing and responding to the interview questions.

The interview and analysis process also made me think about my position as a Christian trainee and how my familiarity with Christian literature and experience of being an individual with Christian beliefs and values may have influenced my interpretations, which also made me question my epistemological position and how findings may have been different had another methodology and epistemological stance been employed .

4.3.1.2. *Participants:* another limitation of this research was the omission of participant factors, such as FLs and CPs background experience of the topic area, which if accounted for would have provided another layer of analysis for inferences to be made about the context and knowledge that participants acted from when answering questions. For example, one FL worked as a psychological wellbeing practitioner, which could have provided a context in which assumptions and interpretations can be made about what was spoken about, specifically in relation to the conceptualisation of MH, role in the process of help and experience and views of collaborating with statutory MHS. However, a degree of inference can be made given that participants volunteered out of their own volition, without remuneration or incentive, to participate, which presumably demonstrated a particular interest in the topic and a degree of homogeneity within and between the participant groups.

Moreover, literature points to the percentage of CPs who are atheist as much greater than the general population (Smiley, 2001; Gallup Foundation, 1996; Office of National Statistics, 2011, 2004; Shafranske & Malony, 1996), therefore, it is interesting to note that the self-selection of CPs who participated all had various degrees spiritual and/or religious convictions, which was not reflective of the statistics, and thus suggests an unrepresented sample group of the clinical psychology profession/population. Furthermore, a limitation of this study is the underrepresentation of female FLs, which may be reflective of the ratio of a males to females in UK FL roles, however, the absence of female voices in this study adds to the an existing void of female experiences and views of a topic area that is currently understudied. Therefore conclusions drawn from this study should be made tentatively as being exploratory of the sample used rather than reflective of London based Christian FLs views and experiences.

4.3.1.3. *Methodology:* FLs sample group was much larger than the CPs', which may have compromised the balance of the TA, although "six interviews are considered sufficient to enable development of meaningful themes and useful interpretations" (Guest et al., 2006, p. 78). Methodological limitations also included data collection. Data such as the years of active ministry for FLs

was not captured and may have provided some context around the extent of their experience of MHS collaboration and contact, though equally, FLs with less years may have more experience of collaboration. Participants' ethnicity was also not captured in the demographic profile, which restricted a layer of analysis from being made in the interpretation of data.

4.3.2. Evaluation

Qualitative research has often been criticised for the space afforded to subjectivity of the researcher (Madill, Jordan & Shirley, 2000). Therefore an important part of evaluating qualitative research requires illustration of evidence to ensure that the process upholds and demonstrates credibility and trustworthiness (Koch, 1994). It has also been argued that different methodological approaches require different criteria for evaluation (e.g., Elliott, Fischer & Rennie, 1999; Yardley, 2000). As there is no single way of measuring it, measuring the quality of qualitative research remains a contentious issue (O'Reilly & Parker, 2013).

Spencer and Ritchie (2012) propose recurrent guiding principles that are relevant across different epistemological perspectives: contribution; rigour; and credibility. Elliott et al. (1999) also offer guidelines on ensuring good quality and standard in qualitative research, which consist of the following criteria: owning one's perspective; situating the sample; situation the sample, and grounding in examples. These authors' guiding principles are combined to structure this section.

4.3.2.1. *Rigour: Owning One's Perspective*: Rigour encompasses reflexivity, auditability and the defensibility of the research (Spencer & Ritchie, 2012). This requires the researcher to 'disclose their values and assumptions, allowing the readers to interpret for themselves the researchers' analysis and consider alternative interpretations' (Elliott et al., 1999. p 221). In order to achieve transparency so that the reader is empowered to understand how personal interpretations influenced data analysis, the theoretical and personal orientation was stated and defined under the headings 'Research Epistemology', and 'Research Reflexivity' (both in [Chapter 2](#)). A section relating to 'Reflexivity' is also

discussed in this chapter and extracts of the reflective journal ([Appendix I](#)) have been included.

4.3.2.2. *Situating The Sample*: The researcher is required to provide descriptive data of participants and their life circumstance to assist the reader in assessing the range of persons and situations to which the findings might be relevant. This information is provided under the heading 'Participants' ([Section 2.6](#)).

4.3.2.3. *Credibility*: Spencer and Ritchie (2012) define credibility as “the extent to which findings are believable and well-founded” (p.234). The use of direct quotations was used to improve understanding and illustrate the basis for the interpretations. In order to minimise the possibility of inaccurate transcription, a clear and consistent approach was taken and transcripts were “checked against the tapes for ‘accuracy’” (Braun & Clarke, 2006, p.36). Gibbs (2007) points out that with some epistemological positions there is no truth, only multiple interpretations of the data. In keeping with a critical realist position, member checks or triangulation were not pursued, as it was deemed that it would not be possible to achieve a direct reflection of reality, only multiple understandings of it.

4.3.2.4. *Grounding In Examples*: This requires the research to provide examples of the questions asked to and the responses given by participants. Excerpts of FLs and CPs' accounts can be found in the Results section ([Chapter 3](#)) and more detailed accounts including questions asked and responses provided can be found in Appendix G1a and G1b. It is hoped that by providing these example the reader can evaluate the interpretations made and other possible interpretations.

4.3.2.5. *Contribution*: This section refers to “the extent to which the study has contributed to the wider knowledge and understanding or had some utility within the original context” (Spencer & Ritchie, 2012, p.233).

Current knowledge about the extent, role, and nature of FBO involvement in MH and help-seeking is limited and an area seldom explored (Leavey, Dura-Vila & King, 2012). There is a paucity of data relating to the relationships between the

FBO and MHS including referral patterns and attitudes of FLs towards MHS (Dein, Lewis & Lowenthal, 2011). This study adds to existing concerns, many of which have been reported in literature for well over ten years, pertaining to FLs feeling ill-equipped to deal with MH issues, MH staff uncertainties and fears of initiating faith talk with service-users, and MH staff lack of confidence in making use of own beliefs in clinical milieu (e.g., Foskett et al. 2004; Dura-Vila et al. 2011). The findings also contribute towards new and emerging evidence base concerning FBO-MH collaborative practices. The novelty of this study is that unlike existing UK research which has focused on psychiatrists' beliefs, views, attitudes and experience of FBO collaboration, it explored CPs and London based Christian FLs accounts. An additional strength and novel aspect of this study is possibly the balance of male and female participants in the clinical psychology group, with a cross sample amongst specialities within London.

Other novel aspects of this study's findings were:

- A reported willingness and desire for FBO-MHS collaboration and a compatibility of approaches and explanatory models of MH between FLs and CPs.
- A bi-directional referral pattern was also discussed by FLs who reported a willingness to refer and support congregant with more secular forms of treatment and intervention, which challenges existing literature that suggests a uni-directional referral pattern.
- Rich descriptions of FBO role and involvement in MH care including the approaches and methods of care, which concluded beliefs and therapeutic modalities to be complementary of and compatible with some MHS and psychological approaches.
- A highlight of current innovative collaborative practices within the UK where FBO work jointly with MHS
- Illustrating a shift in MHS attitudes concerning FBO roles and demonstrating a growing recognition of the FBO contribution in MH care, to the extent that the scale and impact of FBO role is fast becoming a

recognised and valuable contribution in the sight of central organisations and statutory services.

4.4. Implications of The Study

4.4.1. Clinical Practice

The implication of the study's findings on clinical practice highlights a need for collaborative practice and partnership between FBO and MHS. *New Ways of Working* (BPS, 2007) and *Clinical Psychology Leadership Development Framework* (BPS, 2010) advocate consultancy-based work and training in clinical psychology that equips CPs in management, leadership skills and competencies. In light of these documents, CPs are well placed to frontier the way forward for collaborative FBO work and practices. Such approaches of collaborative practice would entail MHS and FBO talking with one another and not to one another, as stipulated by both FLs and CPs in this study. This mechanism is depicted by Anderson and Goolishan (1992), who outline a process through which CPs and FBOs participate in the co-development of meaning and narratives, whereby emphasis is not to produce change but to open spaces for conversations. For example, CPs could also invite FLs to present at CPD sessions and seminars, or offer consultation and formulation sessions that provide the space for the exchanging and sharing of ideas and information relating to MH care in the context of religion and spirituality.

Recommendations deriving from participants' accounts included the need for time-funded roles within MHS so that there is an identified person tasked at building community relationship and engagement who can act as a link-person (conduit-type role) between FBO and MHS. Other recommendations posed by participants included developing a small community steering group of individuals from various MH disciplines and FBO background that could meet together at regular intervals to discuss, share, exchange and build capacity. However, given the economic climate and financial restraints on NHS, this may pose some difficulty for CPs, especially if the MHS "lacks the inclination and resources"

(Farah) to allocate time and funding into developing roles that focus on collaborative practices. Nonetheless, if time-funded post are not available and commissioning statements fail to stipulate interagency work, there should be some attempt of community engagement that at minimal levels notifies the community of the resources and services available to them, so that FBOs do not feel abandonment and unsupported when on the “battle front” working as lay MH staff.

4.4.2. Teaching And Training

FLs could be included in teaching sessions on professional clinical psychology doctorate courses, which could raise awareness of spiritual, religious and cultural issues, in addition to dispelling assumptions about FBO approaches and practices. Likewise, CPs can offer their time and expertise in sharing information, learning about FBO approaches, attending FBO meetings and assisting in training for FLs. However, as already discussed, this type of partnership would have to be from a position of mutual respect and learning, and utilise CEM model of engagement (Fountain et al., 2007).

Drawing from exemplary collaborative practices found in this study, clinical psychology training courses could also work with FBOs in coordinating training placements, similar to placements provided for junior doctors. Education establishments could even organise seminars to familiarise FLs with services and facilitate available to their constituents. Taking into consideration the current study’s findings, CPs could share psychological knowledge to assist FLs in developing guidelines to help assist FLs their role when providing help to congregant members. For example, CPs could also offer information packs or A4 crib sheets that provide bullet point information on what to do if someone is in crisis, and basic self-help ideas and techniques that will add to FLs ‘coming alongside’ tool-box.

4.4.3. Services And Policy

In clinical settings, risk is always measured, however, safety is not a commodity that is easily quantified (Reynolds, 2011). This poses a quandary for organisations such as FBO, whose chief work is ensuring safety, love, and

belonging. FBOs work in a way that addresses the 'un-happenings' of individuals in distress. Reynolds (2011) postulates that these 'un-happening' are all of the things that cannot be measured because they do not happen, and she raises a critical question of how, as MH clinicians, we might attend to all these un-happenings that defy measurement. The absence of measureable outcomes means that FBO prevention-based works, are not witnessed, which have weightier consequences of FBO sustainability.

Helping to build capacity within FBO communities to address the immeasurable outcomes to evidence their work as being valuable and effective, worthy of support and where appropriate, funded, can be an aspect of the CPs role in researching ways in which measurements can be developed. The issues of sustainability due to the ineffable, intangible and untraceable influences of FBO contribution to MH care means that their collective work goes unmeasured. As such, the need for resources and support goes amiss and undetected, and the work of FBOs goes unmeasured and unvalued. CPs are well positioned by virtue of their training to co-develop ways in which FBOs can capture their work so that it is valued and recognised. FBOs can be a focal point, gateway and conduit for policy dissemination and community grievance (Leavey et al., 2007), CPs could contribute towards policies and best practice guidelines in partnership with FBOs to help disseminate and share information that will support both organisations when working on issues of faith, spirituality and MH. Additionally, recommendations and guidelines outlining the parameters and role expectations of FBO in MH care would perhaps reduce FLs concerns about the envisaged changes that are perceived to be inherent with FBO-MHS collaboration (e.g., professionalisation of laity).

4.4.4. Future Research

This study has highlighted the potential of collaborative FBO and MHS work; and despite the current barriers, innovative practices and partnership projects exist locally in London. However, to evaluate and capture these practices, research needs to build upon what is considered a limited and frail evidence base. The qualitative exploration of CPs and Christian FLs views and experience of working with FBO/MHS is in its infancy with an evidence base that is minuscule in

comparison with USA literature. As mentioned previously, the UK evidence base that does exist pertains to psychiatry and FBOs collaborative practices, therefore further evaluative research exploring collaborative approaches with FLs and CPs would be beneficial to the sparse literature that currently exists as any increase in research in this topic area could influence governing bodies to promote integrative services (Pouchly, 2011).

This study has also highlighted what seems to be an openness between both parties in having an exchange of discussions and dialogues regarding their role, practices and involvement in mental health care of religious and spiritual service-users/congregants; which has struck me as a shift in the level of reported scepticism between both parties that has historically been documented in literature. Therefore a valuable and worthwhile contribution to research following on from the current study would be to ascertain the views of FBO congregants concerning conceptualisations of MH, help-seeking behaviour and perceptions of statutory MHS care and psychological therapy, as this may provide insight into the barriers of accessing MH care and talking therapies.

If future research were to build specifically upon the present study, it should focus on exploring UK CPs and FLs views and experiences of collaborative practices, with a sample group sizes that is comparable so as to provide a balanced reflection of views and experiences. Another area of development would also be to ascertain the views of service-users (for whom spirituality and religion are of importance) concerning MHS-FBO collaborative practices and approaches in the form of either individual interviews or focus groups.

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6. APPENDIX

6.1. Appendix A1. CPs' Information Sheet



UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water London E15 4LZ

RESEARCH INFORMATION SHEET

The Principal Investigator

Nadia Elijah Joseph: School of Psychology, Stratford Campus, Water London E15 4LZ.
Email:[deleted for confidentiality purposes] Telephone: [deleted for confidentiality purposes]

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider when deciding whether or not to participate in this research study. The study is being conducted as part of a Clinical Psychology Doctorate degree at the University of East London. Please take your time to read the following information carefully.

Project Title

THE SACRED, SUPERNATURAL AND SPIRITUAL: ATTITUDES AND BELIEFS OF FAITH LEADERS AND MENTAL HEALTH CLINICIANS REGARDING MENTAL HEALTH AND RELIGION

What is the purpose of the study?

This study proposes to explore links between mental health services and Faith Based Organisations (FBOs) by examining the beliefs, attitudes and experiences held by both parties regarding mental health and spirituality/religion. It will explore the experiences of faith leaders and clinical psychologists in their roles when working with someone who has a spiritual/religious belief and mental health problem. It will also explore the barriers and benefits of working collaboratively with FBOs and the mental health service.

What will happen if I choose to take part?

You will be asked to sign a consent form stating that you are happy to take part in the study. Following this, you will be invited to attend a one-to-one, confidential interview at a time and place convenient for yourself. The researcher will ask questions about your views on mental health and religion and how these impact case management/care, your experience of working with someone who has spiritual/faith/religious beliefs and mental health problems, and the barriers and benefits of working collaboratively with FBO. The interview is around 15-40 minutes in duration and will be audio recorded by the researcher and transcribed by the researcher and/or a research assistant. You will be given the opportunity to ask questions before and after the interview.

What if I become distressed during the interview?

Although this is unlikely, it is possible that the subject area being discussed may be upsetting for you. You are free to leave the interview at any time. You are also free to take a break from the interview and return if and when you feel able to resume. The researcher can also give you contact details for further support, should you wish. There are no known risks to participating in this study, however in the unlikelyhood of the interview being distressing for you, it is also possible that you may think about or even re-experience difficult event that happened to you in the past.

Confidentiality of the Data

Your identity will be anonymous in the research and any publications that arise from the research. No information provided by participants that would enable others to identify particular individuals will be permitted to enter the public domain. All data collected will be encrypted and stored on a password protected office computer, which is stored securely on University of East London network and a secure password-protected website. Once the project is complete, the data will be removed from the hard drive and securely stored by the Graduate School in accordance with the Data Protection Act 1998.

Remuneration

Participants will not be reimbursed for travel costs that may incur as a result of attending the interview.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Ethical Approval

This research project has received Ethical Approval from University of East London and Research and Development (R&D) Approval from East London Trust NHS (Project ID number - ReDA Ref: AF1307/1)

Contact for further information

Thank you for taking the time to read this leaflet. Please feel free to contact me with any questions you may have. If you are happy to participate you will be asked to sign a consent form prior to the interview. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study will or has been conducted, please contact me on the details above or the project supervisor Dr. Maria Castro, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: m.castrol@uel.ac.uk)

If you have a complaint about the way the study is being conducted please contact University Research Ethics Committee - Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Yours sincerely,

Nadia Elijah Joseph
Trainee Clinical Psychologist
28/11/2012

6.2. Appendix A2. FBO Information Sheet



UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water London E15 4LZ

RESEARCH INFORMATION SHEET

The Principal Investigator

Nadia Elijah Joseph: School of Psychology, Stratford Campus, Water London E15 4LZ.

Email: [deleted for confidentiality purposes] Telephone: [deleted for confidentiality purposes]

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider when deciding whether or not to participate in this research study. The study is being conducted as part of a Clinical Psychology Doctorate degree at the University of East London. Please take your time to read the following information carefully.

Project Title

THE SACRED, SUPERNATURAL AND SPIRITUAL: ATTITUDES AND BELIEFS OF FAITH LEADERS AND MENTAL HEALTH CLINICIANS REGARDING MENTAL HEALTH AND RELIGION

What is the purpose of the study?

This study proposes to explore links between mental health services and Faith Based Organisations (FBOs) by examining the beliefs, attitudes and experiences held by both parties regarding mental health and spirituality and/or religion. It will explore the beliefs and experiences of faith leaders and clinical psychologists about mental health and spirituality and/or religion; examine whether issues of mental health feature in the role of faith leaders, and explore the barriers and benefits of working with mental health services.

Who can participate?

You can participate if you hold a leadership position within a Christian religious/faith organisation, for example a church leader, pastor, priest, bishop, etc. You do not need to have had experience of working with congregants with mental health problems to participate.

What will happen if I choose to take part?

You will be asked to sign a consent form stating that you are happy to take part in the study. Following this, you will be invited to attend a one-to-one, confidential interview at a time and place convenient for yourself. The researcher will ask questions about your views on mental health and religion and how these impact case management/care, your views and/or experience of working with someone who has spiritual/faith/religious beliefs and mental health problems, and the barriers and benefits of working collaboratively with the mental health service. The interview is around 15-40 minutes in duration and will be audio recorded by the researcher and transcribed by the researcher and/or a research assistant. You will be given the opportunity to ask questions before and after the interview and will be free to end the interview at any time as well as withdrawing from the study, at any point.

What if I become distressed during the interview?

Although this is unlikely, it is possible that the subject area being discussed may be upsetting for you. You are free to leave the interview at any time. You are also free to take a break from the interview and return if and when you feel able to resume. The researcher can also give you contact details for further support, should you wish. There are no known risks to participating in this study, however in the unlikelyhood of the interview being distressing for you, it is also possible that you may think about or even re-experience difficult event that happened to you in the past.

Confidentiality of the Data

Your identity will be anonymous in the research and any publications that arise from the research. No information provided by participants that would enable others to identify particular individuals will be permitted to enter the public domain. All data collected will be encrypted and stored on a password protected office computer, which is stored securely on University of East London network and a secure password-protected website. Once the project is complete, the data will be removed from the hard drive and securely stored by the Graduate School in accordance with the Data Protection Act 1998.

Remuneration

Participants will not be reimbursed for travel costs that may incur as a result of attending the interview.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Ethical Approval

This research project has received Ethical Approval from University of East London and Research and Development (R&D) Approval from East London Trust NHS (Project ID number - ReDA Ref: AF1307/1)

Contact for further information

Thank you for taking the time to read this leaflet. Please feel free to contact me with any questions you may have. If you are happy to participate you will be asked to sign a consent form prior to the interview. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study will or has been conducted, please contact me on the details above or the project supervisor Dr. Maria Castro, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: m.castrol@uel.ac.uk)

If you have a complaint about the way the study is being conducted please contact University Research Ethics Committee - Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Yours sincerely,

Nadia Elijah Joseph
Trainee Clinical Psychologist
28/11/2012

6.3. Appendix B. Consent Form



UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water London E15 4LZ

CONSENT FORM

Consent to participate in a research study

The Sacred, Supernatural and Spiritual: Attitudes and Beliefs of Faith Leaders and Mental Health Clinicians Regarding Mental Health and Religion

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that the interview will be audio-taped and direct quotes may be used in the written study. I understand that particular data from this study will remain strictly confidential. I understand that only the researcher(s) involved in the study will have access to identifying data and it has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Date:.....

I confirm that I have explained the nature of the study as detailed in the participant information sheet and I believe that the consent given by this participant is based on their clear understanding, in my opinion

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:.....

6.4. Appendix C1. University Of East London School Of Psychology Ethics Committee Approval Letter

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Maria Castro

ASSESSOR: Lara Frumkin

STUDENT: Nadia Joseph

DATE (sent to assessor): 24/06/2013

Proposed research topic: THE SACRED, SUPERNATURAL AND SPIRITUAL:
ATTITUDES AND BELIEFS OF FAITH LEADERS AND MENTAL HEALTH
CLINICIANS

Course: Professional Doctorate in Clinical Psychology

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | NA |
| 8. Is procedure that might cause distress to participants ethical? | NA |
| 9. If there are inducements to take part in the project is this ethical? | NA |

10. If there are any other ethical issues involved, are they a problem? NO

APPROVED

YES

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: LF Date: 24/6/13

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Maria Castro

ASSESSOR: Lara Frumkin

STUDENT: Nadia Joseph

DATE (sent to assessor): 24/06/2013

Proposed research topic: THE SACRED, SUPERNATURAL AND SPIRITUAL:
ATTITUDES AND BELIEFS OF FAITH LEADERS AND MENTAL HEALTH
CLINICIANS

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|----------------------------------------|----|
| 1 | Emotional | NO |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		
-----	--	--

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: LF Date: 24/6/13

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4986 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2863



6.5. Appendix C2. UEL Letter of Approval of Minor Amendments

February 2013

Dear Nadia

Re: Registration Board

Thank you for your amended research proposal and for your letter detailing your response to the points raised in relation to your original proposal. I am satisfied that you have successfully addressed the issues identified in my previous letter to you, and I am writing to inform you that your proposal can now be considered at the Clinical psychology Sub-Group of the School Research Degrees Sub-Committee on 4th March. You should complete the "Registration for a Postgraduate Research Degree" form, which is available at <http://www.uel.ac.uk/qa/pgr/index.htm>. The Research Proposal will comprise the section entitled "**PROPOSED PLAN OF WORK, INCLUDING ITS RELATIONSHIP TO PREVIOUS WORK**". Please note that the maximum permitted word count for this section is 4,000 words, so you can expand on the information contained in your submitted research proposal should you so wish. The information that you will need in order to complete the sections on your research supervisors is available on UEL Plus. You should email a copy of the completed form to Claire and to me by Monday 25th February at the very latest.

You are now permitted to proceed to apply for approval from the UEL School of Psychology Research Ethics Committee and any other relevant ethics committee(s).

Best wishes for every success with your research.

Yours sincerely

Kenneth Gannon
Research Director

6.6. Appendix C3. FINAL R&D APPROVAL



Joint Research Management Office
Queen Mary Innovation Centre
5 Walden Street
London E1 2EF
Tel: 020 7882 7260
Fax: 020 7882 7276
Email: Sponsorsrep@bartshealth.nhs.uk

Protocol: The Sacred, Supernatural and Spiritual: attitudes and beliefs of faith leaders and mental health clinicians regarding religion and mental health

ReDA Ref: AF1307/1
REC Ref: UEL REC Reviewed

I am pleased to inform you that the Joint Research Management Office for Barts Health NHS Trust and Queen Mary University of London has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of East London Foundation Trust. Approved study documents are as follows:

Type	Version	Date
REC approval	UEL	24.06.2013
Protocol		12.12.2012
Participant Information Sheet		28.11.2012

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BH and QMUL policies that reinforce them, you can obtain details from the Joint Research Management Office or go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint Research Management Office during the course of the research project, in particular:

- ☐ If there is a change of Principal Investigator
- ☐ When the project finishes
- ☐ If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or

staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 020 7480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely

A handwritten signature in black ink, appearing to be 'GLe', written in a cursive style.

Gerry Leonard, Head of Research Resources

Copy to: CI – xxx

6.7. Appendix D. Distress and Debriefing Information

Sane Line - SANE runs a national, out-of-hours mental health helpline offering specialist emotional support and information to anyone affected by mental illness, including family, friends and carers. SANE is open every day of the year from 6pm to 11pm and can be contacted on 08457678000 or http://www.sane.org.uk/what_we_do/support/

Samaritans – Samaritans is open 24hrs a day every day of the year. You can contact them by email jo@samaritans.org or phone 08457 90 90 90 (call charges apply). <http://www.samaritans.org>

MIND UK- Mind provide free information and advice. You can contact them free by phone on 0300 123 3393 or by email info@mind.org.uk. Alternatively, you can walk into your local MIND where an advisor will be able to help you.

In the unlikelyhood of becoming extremely distress, please go to your local A&E who will be able to offer further support and guidance

6.8. Appendix E1. Clinical Psychologists' Interview Schedule

PSYCHOLOGISTS' INTERVIEW SCHEDULE

(a) The relationship between MH and religion/spirituality

- How would you describe your own spiritual or religious beliefs?
- What are your views about the relationship between mental and spirituality/religion?

What factors do you think influence those views?

(b) Experience of working with someone who has spiritual/religious beliefs

- Have religious/spiritual issues ever been important in your practice?
- Tell me about your experience of working with someone who has had spiritual/religious beliefs?

Prompts: Can you provide an example of when religious/spiritual issues have been important in your practice?

- What influences the way in which you work with someone who has spiritual/religious beliefs?

Prompts: How does your belief influence the way in which you work with your patients? Can you give me an example?

(c) Collaboration

- Have you ever liaised with faith leaders (for example an imam or pastor, priest etc) when working with a patient whose religion or spirituality has been important?
- What are your views/experiences of working with faith leaders

Yes	No
What has been your experience of working with faith based organisations?	What prevented you? What if you had a case where that

<p>What was your Involvement?</p> <p>-How did you support the person you work with in that process?</p> <p>In your experience what facilitated or hampered working with faith leaders</p>	<p>was appropriate, what would facilitate or hamper working with a faith leader?</p> <p>If you can imagine a time where it was appropriate, what would facilitate or hamper working with a faith leader?</p>
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6.9. Appendix E2. FBO Interview Schedule

FBO INTERVIEW SCHEDULE

(c) The relationship between MH and religion/spirituality

- How would you describe your own spiritual or religious beliefs?
- What is your perspective on mental health?
- What are your views about the relationship between mental and spirituality/religion?
- What factors do you think influence/affect those views?

(d) MH issues part of faith leaders' role/ Management of MH patients with religious/spiritual beliefs

- Have mental health issues ever been important in your practice or a feature of your duties as a faith leader?

Prompts: Example of work

- Tell me about your experience of working with a church member who has had MH problems?

(c) Collaboration

- What are your views/experiences of working with MH system when supporting a church member who has mental health problems?
 - Have you ever liaised with the mental health system (for example a psychiatrist, nurse or psychologist) when supporting a church member where issues of mental health have been present?

Experience	No experience
Involvement? -How did you support the	What prevented you?

<p>person you work with in that process?</p> <p>In your experience what facilitated or hampered working with MH system</p> <p>What have been the barriers?</p>	<p>If you were aware of an individual with mental health problems in your church, what might your involvement be?</p> <p>How would you seek help?</p> <p>Would you liaise with mental health clinician if a church member appeared to have a mental health problem?</p> <p>What if you had a case where that was appropriate, how would you see your involvement?</p> <p>What would facilitate or hamper working with the mental health system, such as a psychologist?</p>
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6.10. Appendix F1. CPs Pre-Interview Questionnaire

The Sacred, Supernatural and Spiritual: Attitudes and Beliefs of Faith Leaders and Mental Health Clinicians Regarding Mental Health and Religion

Terminology: If it helps to differentiate between 'spirituality' and 'religion', then please let me know what each means to you and I will adopt your definition and preference.

Please complete the below pre-interview questions

Age:

Gender:

How many years have you been qualified?

What is your religious/spiritual belief? For example, agnostic

**What type of service do you work in? For example, CAMHS Youth
Offending**

Thank you!

6.11. Appendix F2. FBO Pre-Interview Questionnaire

The Sacred, Supernatural and Spiritual: Attitudes and Beliefs of Faith Leaders and Mental Health Clinicians Regarding Mental Health and Religion

Terminology: If it helps to differentiate between 'spirituality' and 'religion', then please let me know what each means to you and I will adopt your definition and preference.

Please complete the below pre-interview questions

Age:

Gender:

What is your religious/spiritual belief? *E.g. Christian*

Denomination and place of worship? *E.g. Messianic Jew, worship at a synagogue*

Position in leadership? *E.g Bishop*

Thank you!

[illegible]

6.13. Appendix G1b. FL Sample Transcript and Annotated Comments and Preliminary Codes

Participant 13 interviewed 14/11/13, Duration 17m 13s

54 I wish also there that's open every day 000
 55 on chatting to folk that are just dealing with
 56 ordinary issues and then you know coming to
 57 terms with different aspects of their own
 58 mental health through.

59 I see something and there any other examples
 60 you could provide at your role
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Participant 13 interviewed 14/11/13, Duration 17m 37s

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Participant 13 interviewed 14/11/13, Duration 17m 37s

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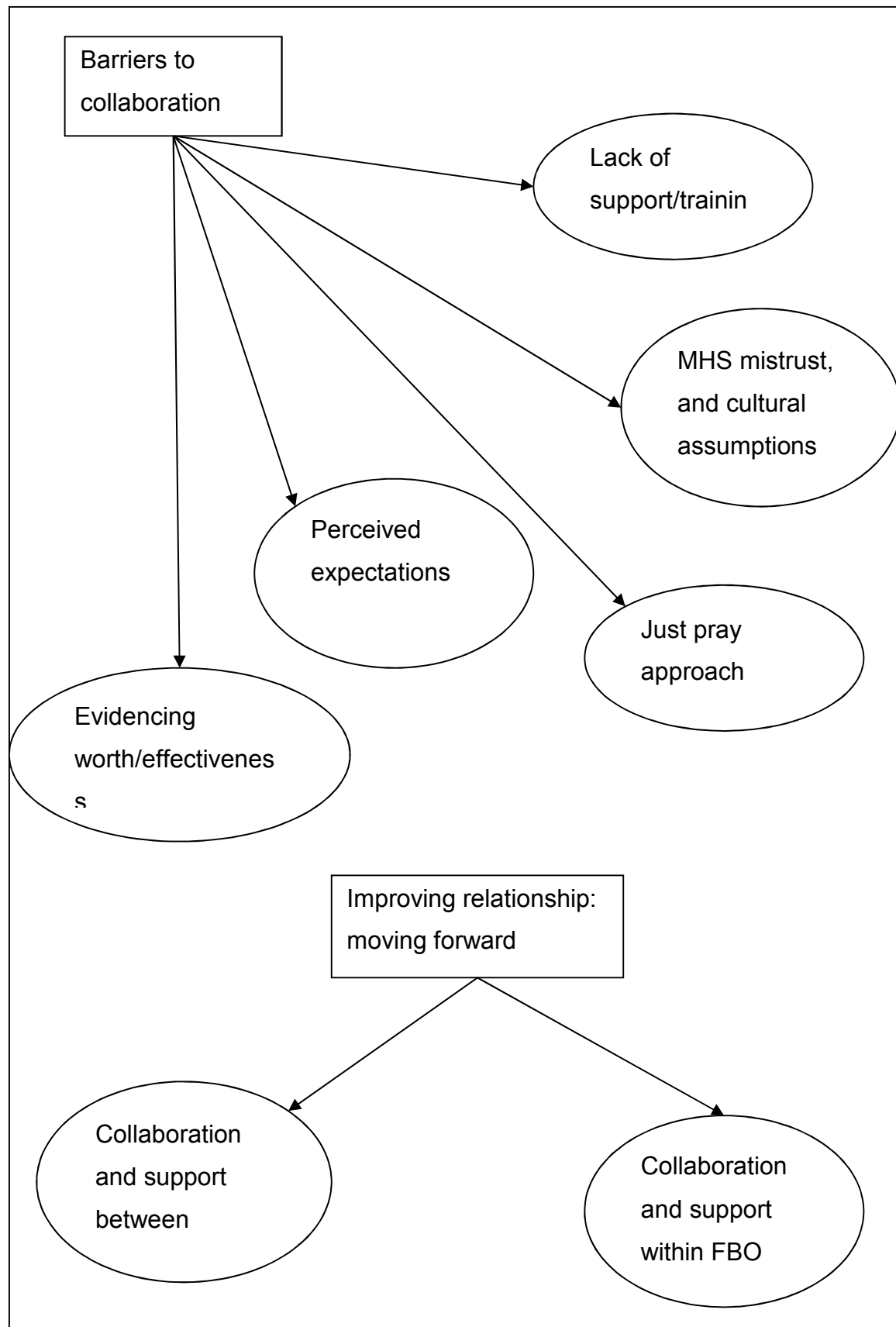
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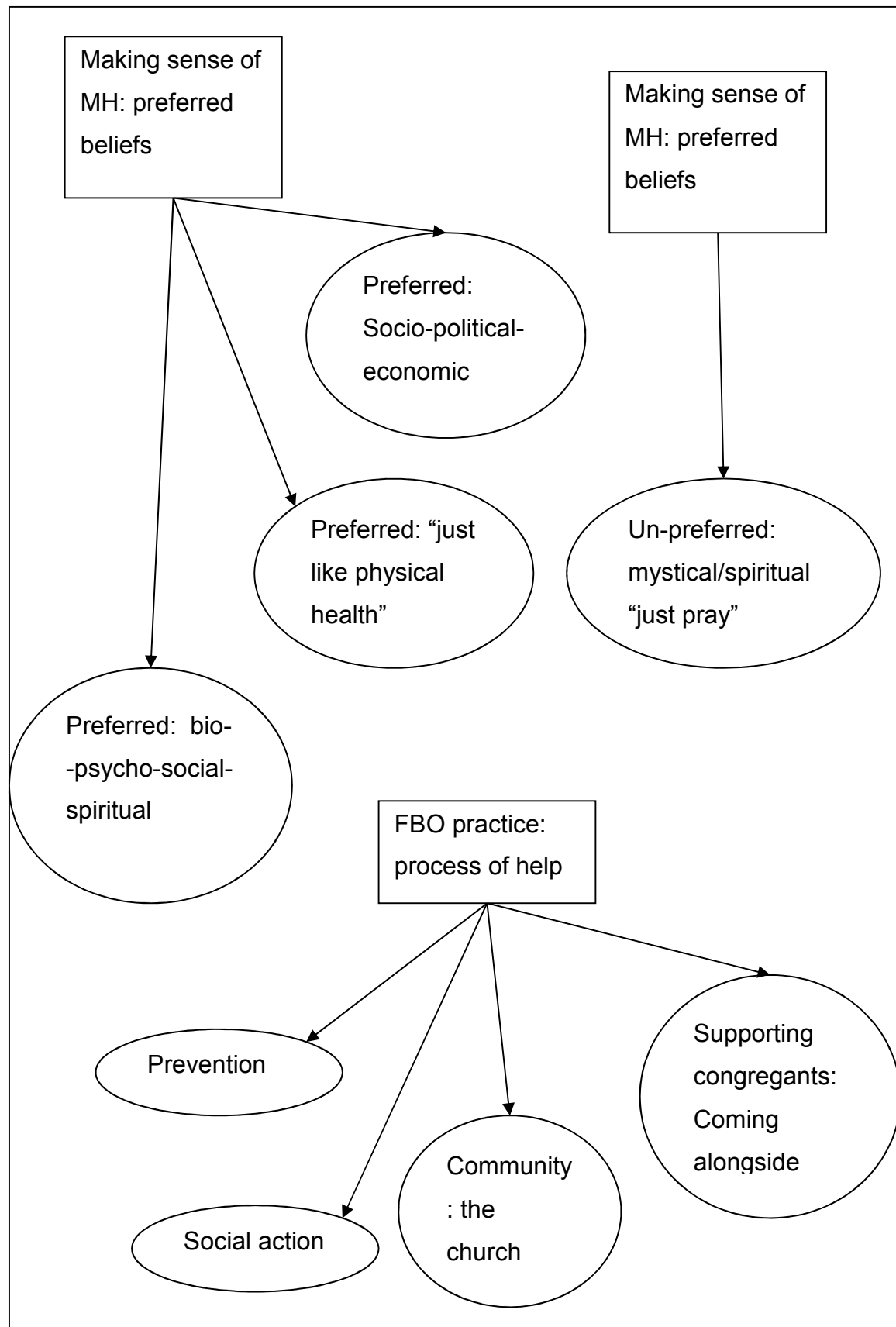
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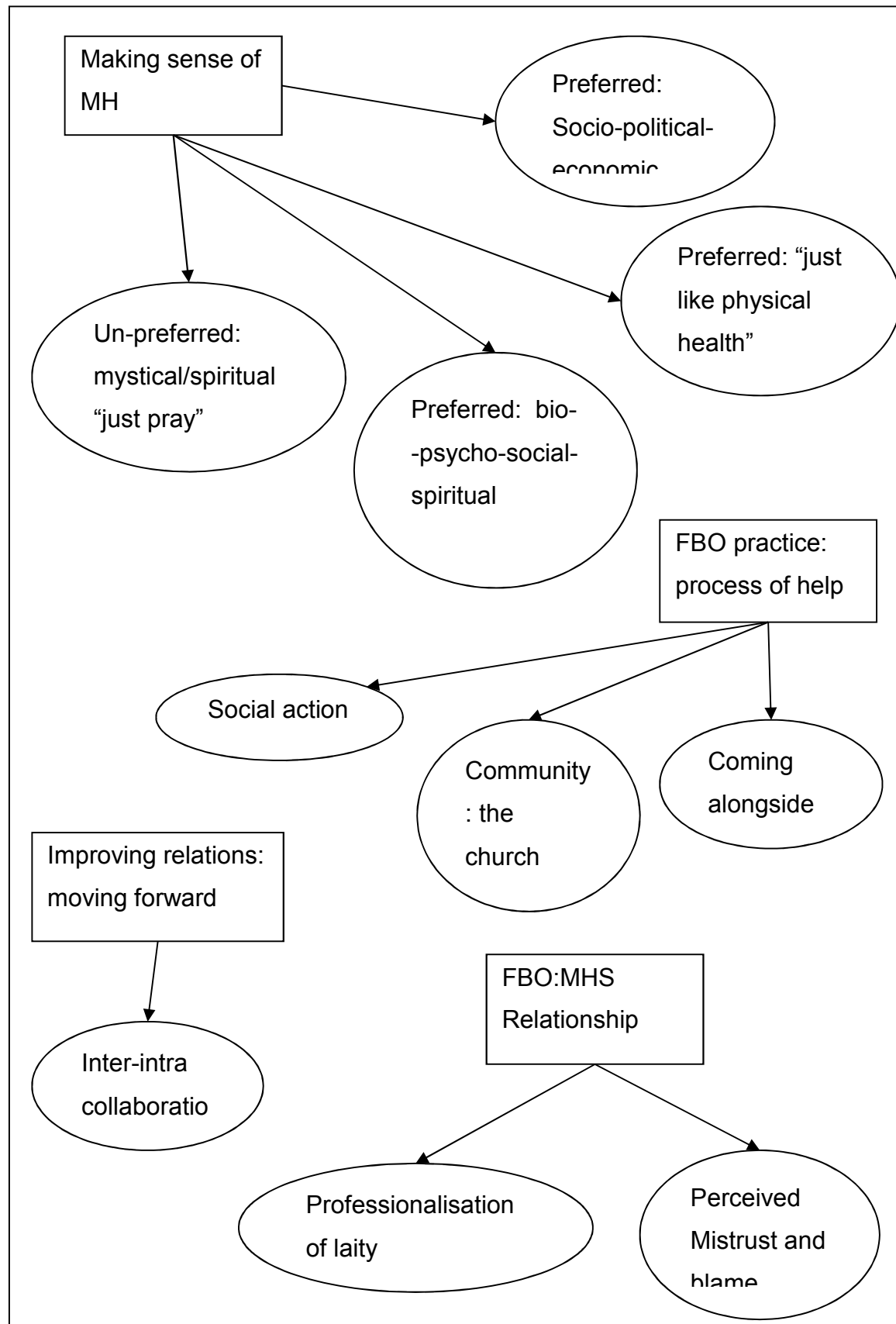
6.15. Appendix G2. FL Initial superordinate and subordinate themes



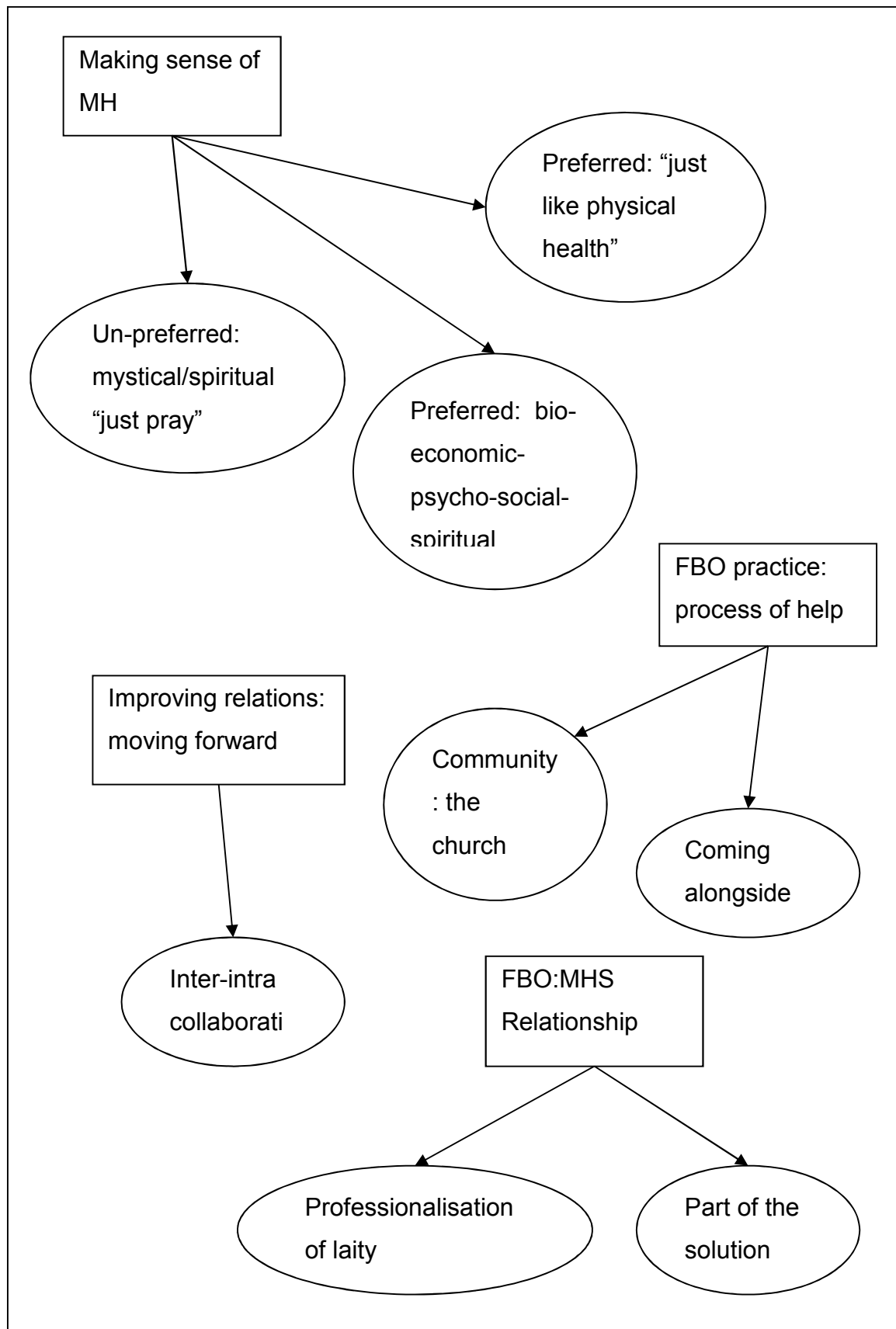
6.16. Appendix G2. FL Initial Themes Continued...



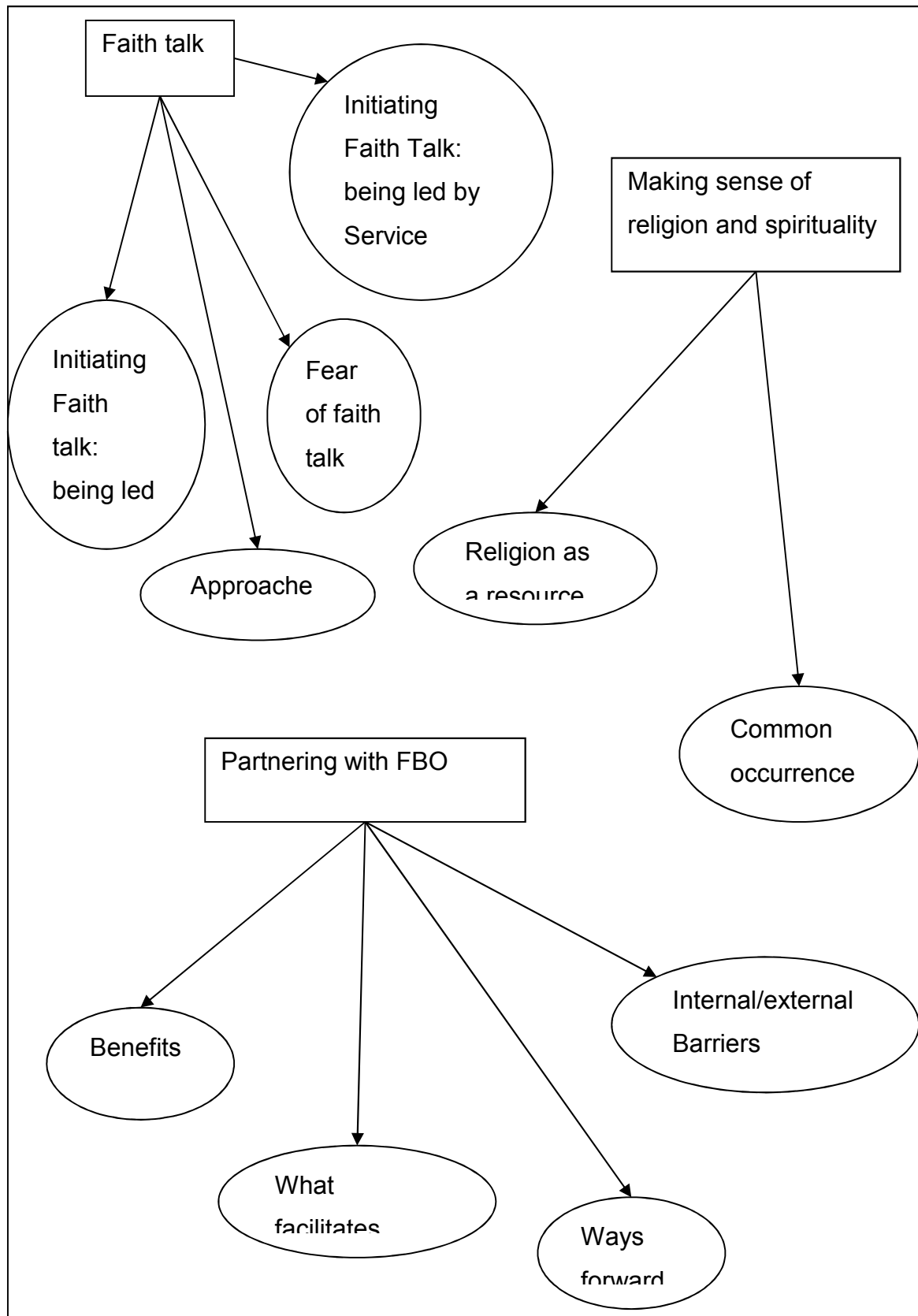
6.17. Appendix G3. FL Map 2 Superordinate and Subordinate Themes



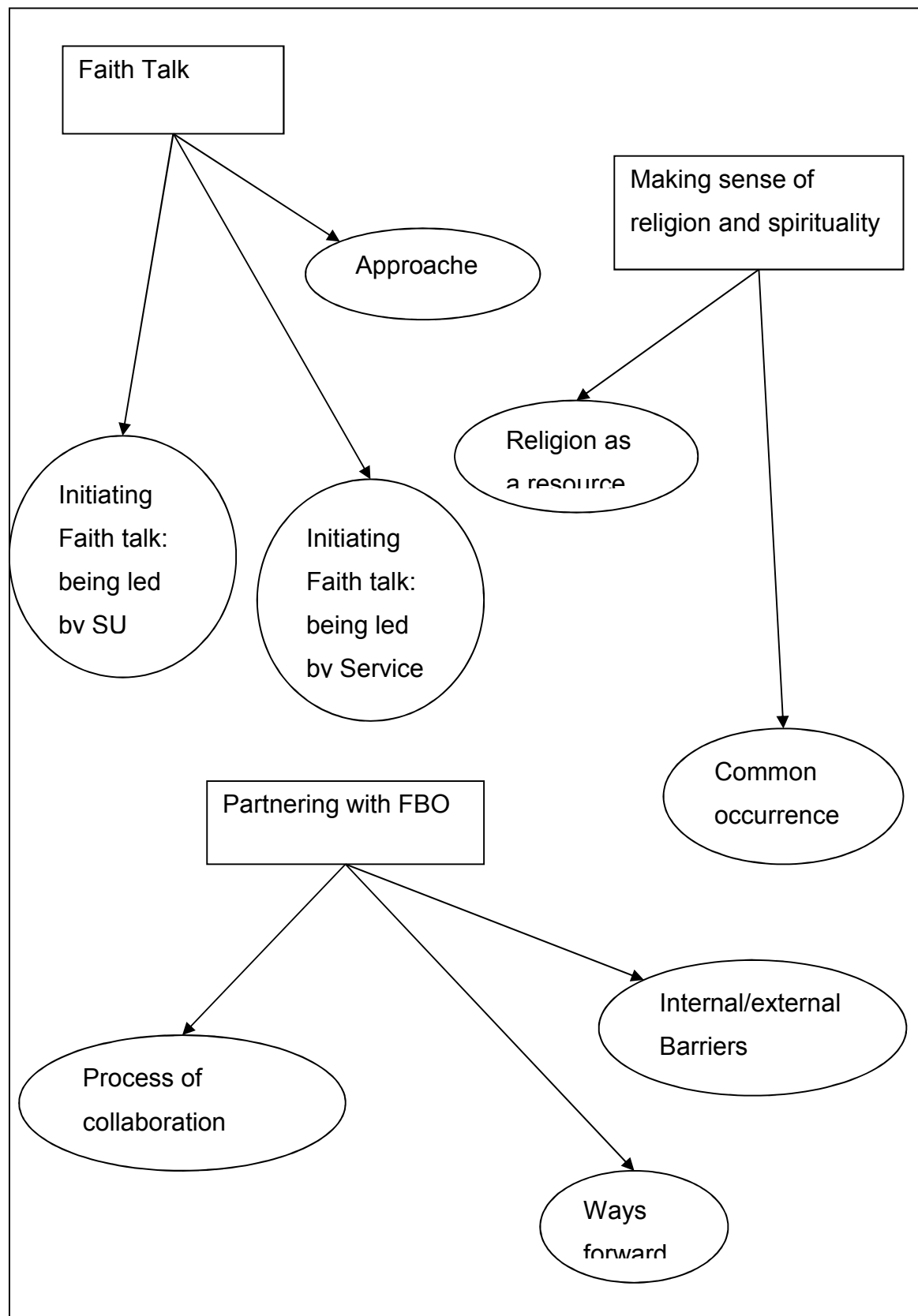
6.18. Appendix G4. FL Final Superordinate and Subordinate Themes



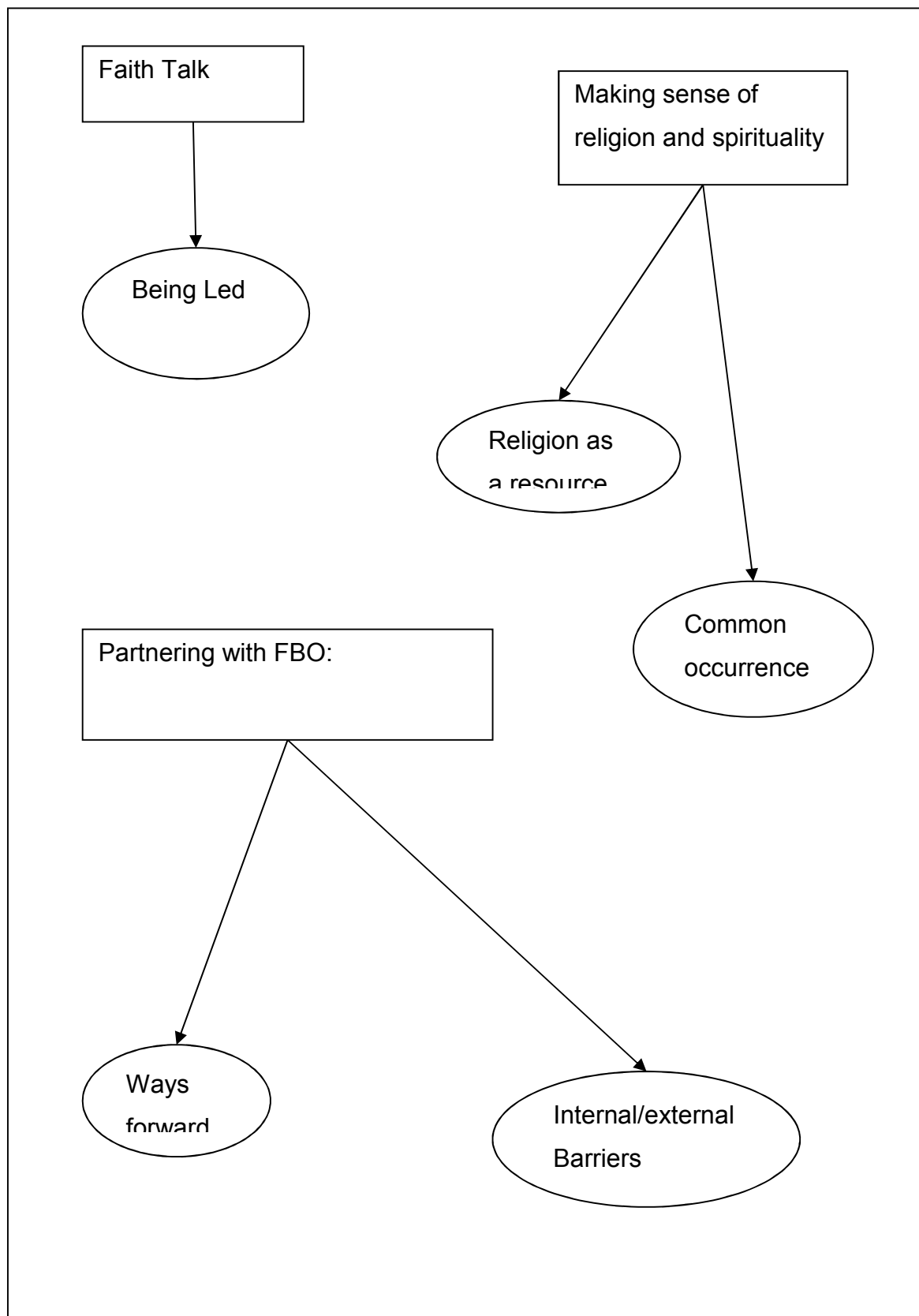
6.19. Appendix G5. CP Initial Superordinate and Subordinate themes



6.20. Appendix G6. CP Map 2 Superordinate and Subordinate Themes



6.21. Appendix G7. CP Final Superordinate and Subordinate Themes



6.22. Appendix H1. FL Sample of Coded Transcript, Superordinate and Subordinate themes

FL #	transcripts	notes	codes	subordinate theme	superordinate theme
F1:16	I believe it is mainly caused by depression and stressed		conceptualisations of MH. Preferred beliefs	preferred: bio-economic-psycho-social-spiritual	making sense of MH
F1:29	er mental health, my view is even though I believe in God and I believe in the power of prayer but I also believe in profession like professional counsellors professional counsellors who are qualified to speak into their lives erm I also some people just believe in prayer alone but to me I believe that prayer works but people should also go to the hospital and get medication		importance of prayer & medication in tx - dual role. Medical model; biopsychosocial determinants. Scriptural evidence	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F2:92	yep, yep many people have had mental iness here over time and um you know and dealing with people and that many people have it as a short term response to breavement many people have it as a response to something anxious has happened in their life, many people just have it as a natural response of of how they've dealt with life really		MH response to psychosocial events. Nautral occurrence. eg bereavement	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F2:36	we've got a number of people that are sort of (.3) sort of quite um mentally frail in how they sort of deal with thing how they respond to things		some are mentally fail than others - idea of vulnerability, fragility, fallability	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F1:69	specifically mental but various em problems that occur in people's lives like marriage, em you know financial problems.	impact of material realities	socio-economic-politic factors contribute to mh problems	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F1:350-354	it because of this fake freedom that they are trying to give our children...we live in a world today that if they want to give an aspirin or paracetamol to your daughter or your son they will call you for confirmation, but when she's pregnant and want to abort they tell her you don't have to inform your parents you can do it yourself here.	false freedom, false consciousness. State vs. individual personal agency/responsibility. Loss of control/power.		preferred: bio-economic-psycho-social-spiritual	making sense of mh
F7:31	a personal perspective is that mental health as a result of the fall at the beginning of creation no more no less and because we live in a broken world it's inevitable that not only do we see people with physical disabilities either hereditary or caused by accidents and so forth or caused by diseases natural causes biblically it'll be inevitable and someway psychologically would be effected and so mental health at the end of the day is part of fall in creation um people with mental health need to be loved just as much as anyone else pure and simple	MH result of living in broken world according to biblical/spiritual accounts. Religious beliefs inform views re MH. Spiritual aspect of mh	bibilica/spiritual explanation	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F7:810	I'd be interested to know the correlation between mental health problems and the breakdown of the social structures of this nation		result of breakdowns in social structures	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F2:31	um I see it as a completely normal part of life really and something that er er that we all struggle with really		Normal part of life - all struggle	preferred: bio-economic-psycho-social-spiritual	making sense of mh
F3a:29	I would just say that mental health is almost no different to working with ordinary people so that that its almost an unfair distinction if you like so in the same way that any church can be filled with people who are working or not working or happy or sad or um you know I: It's like a spectrum almost? F3a: Yeah, perhaps it's a best way. That's a good word to use		MH on spectrum	preferred: like physical health (spectrum- continuum)	making sense of mh

6.23. Appendix H2. CP Sample of Coded Transcript, Superordinate and Subordinate theme

CP #	transcript	notes	codes	subordinate theme	superordinate theme
CP4:42-47	i don't tend to go about talking about it unless people ask me explicit questions admittedly	fear of initiating faith talk. Being led by su	initiating faith talk	being led	faith talk
CP4:45-47	when they do ask me i still feel a sense of oh god they are asking me what am i going to say right how are they going to perceive what i am going to say	impact of 'what ifs'? perception of self from others. uncertainty of the unknown? Mason unsafe uncertain	initiating faith talk	being led	faith talk
CP3:77-81	I shy away conversations where people are really against it or try and get into discussions around faith and religions	shies away from engaging unless su initiates - whose resp	initiating faith talk	being led	faith talk
CP4:248-251	luckily we've got people in our team who are quite well versed within different faiths so they able to lend their own but they're quite anxious about it	self-censor/police beliefs. Personal/professiona l context? - Spirituality/religion illegitimate topic unmedical	initiating faith talk	being led	faith talk
CP2:231	i think when people are really i think the ward team's fear is that people could be labelled believing things that aren't you know it's not a medical religion is not really seen as the medical sphere and if you working on a ward a lot of staff keep that down and i think um i think coming in with that idea that it's okay to believe what you want to believe i just want to hear what you have to say and i think that serves serves to sort of function	staff abdicate knowledge due to fear of being construed as unmedical	initiating faith talk	being led	faith talk
CP4:214	with spirituality if they're talking if they introduce the topic of spirituality then i'd follow it but even in my assessment i'd always ask about their spiritual beliefs how much they practice and what influences	creating space of permission. CP responsibility to create safe space. Initiating faith talk led by service user	initiating faith talk	being led	faith talk
CP2:93	people are coming to the wards a lot of Muslim people a lot of Jewish um Christian catholic people and even those who aren't religious can find a lot of comfort or a lot of power in explaining what's going on for them in religious could say in metaphor as a way of putting a word to it but it's not really a metaphor but using that language to explain what's going on for them whether it comes across as a delusional explanation or a you know it fits with the community that they're in	religious language/discourses as therapeutic metaphor/tool. utility of religion	engaging in faith talk: approaches	being led	faith talk
CP4:252	whereas just a couple of weeks ago i sat in a whole session just talking to someone about the bible and they were reading passages we were reading passages together about what helped them and stuff like that and then putting that in conjunction with the therapy that we do and the medication that they take	reading sacred text together	engaging in faith talk: approaches	being led	faith talk
CP6:46	for the most part it tends not to play a role now granted i work more you know neuropsychological field and so some of the religious specific religious content is not ordinary topic what discussion or interaction or concern actually	impact of service context/ top down process of inquiry. Service shapes culture of inquiry/impact of policy	service context	being led	faith talk
CP5:55	especially in this setting forensic mental health setting it's more of a practice that people will allow me to talk about so they pray or they like going to church and things	impact of service context/policy. Approaches to faith talk	service context	being led	faith talk
CP4:235	It's routine within the service but often within the service it's do they have spiritual beliefs yes no what are they it's xyz	inquiring and initiating faith talk predicated on service context. Routine ax	service context	being led	faith talk

6.24. Appendix I. Extracts From Reflective Journal

“CP 4 much longer than other interviews. CP4 was particularly interested in subject area; perhaps reflects length of interview? I wonder to what extent participants’ own interest in the subject area influences what is being discussed. Maybe my own personal interest concerning religion and mental health influence this process... How does my own Christian identity and experiences influence what I say or don’t say in response to participants’ answers. Notice myself nodding a lot in agreement with some of what CP4 was saying and perhaps being less questioning of his answers. I need to consider the ‘lenses’ through which am I using to understand participants experiences and accounts. Am I foreclosing conversations? Need to bear this in mind - discuss with supervisor the effects and impacts of these ‘lenses’”

“First FL interview! FL inquired about my religious affiliation and beliefs, questioned why I chose this topic area. I felt happy to answer, although the question was posed at the end. If he had questioned me at the beginning how comfortable would I have felt? I don’t think I would be too comfortable answering. Surely my answer would influence their responses as there would be a voiced similarity shared between us...social desirability factors need to be considered. If I am asked prior to the interview I will answer. To not answer may raise suspicion, mistrust, and power imbalance (i.e., you answer my questions and disclose information but I will withhold and deny you of your interest/queries).2