**Between the *‘Whispers’* of *‘the Devil’* and *‘the Revelation of the Word’*: Christian Clergy’s Mental Health Literacy and Pastoral Support for BME Congregants**

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Understanding Christian clergy’s role in providing counselling and spiritual support to

Black and minority ethnic (BME) groups offers promise for redressing the ethnicity-related health inequalities in mental health help-seeking and service utilisation in the United Kingdom. This qualitative study (N = 10) investigated the pastoral practices, mental health literacy and referral tendencies of Christian clergy serving BME congregants in Glasgow, Scotland. The qualitative content analysis revealed that clergy held multiple and complex explanatory models of socio-emotional problems, and espoused referrals to health professionals to varying degrees. Clergy-practitioner collaborations can potentially become a crucial enabler of culturally-sensitive and person-centred care, although several barriers persist.

Keywords: clergy; BME; mental health literacy; pastoral

The rapid growth of various ethnic and linguistic communities in the United Kingdom (UK) over the last 15-20 years (Office for National Statistics, 2016; Scotland’s Census, 2011) demands adequate statutory and non-statutory multi-agency provisions to ensure access to effective and culturally responsive healthcare services for the entire population (NHS Health Scotland, 2014; Szczepura, 2005).

Despite policy and legislation mandates (Home Office 2000; Scottish Executive Health Department 2002), national epidemiological and ethnicitylinkage data have shown marked ethnicity-related mental health differentials in the British BME population including a higher incidence of dementia and depression (Fitzpatrick, Kumar, Nkansa-Dwamena, & Thorne, 2014), psychosis (Bansal et al., 2014; Singh & Grange, 2006), and higher rates of mental health diagnosis and admissions (Bansal et al., 2014; Institute of Race Relations, 2014; Care Quality Commission/ National Mental Health Development Unit, 2011) than White British people. Relative to their White counterparts, BME groups also seem less likely to utilise, and remain engaged in, general practitioner (GP) and mental health services for severe mental illness (Bansal et al., 2014; Singh, Islam, Brown, Gajwani, Jasani, Rabiee, & Parsons, 2013).

The Scottish Health and Ethnicity Linkage Study (SHELS) show considerable ethnic variations in mental health hospitalisation rates (Bansal et al., 2014). Specifically, for non-White groups (any Mixed Background, African and Chinese groups), SHELS data indicate under- and late utilisation of mental health services (Bansal et al., 2014). Furthermore, African men and women residing in Scotland appear to have a higher risk of psychotic disorder than the White Scottish population, even after adjusting for socio-economic position (Bansal et al., 2014). The observed inequalities in mental health outcomes and utilisation rate are possibly multi-determined and may warrant consideration of socio-economic and socio-cultural factors (Bansal et al., 2014; Glasgow Centre for Population Health, 2017; Smith, Chaturvedi, Harding, Nazroo, & Williams, 2000). The potential role of religious communities, faith and family support networks, among other forms of social capital, has been highlighted, although specific causal mechanisms tend to lack or are underspecified (Smith et al., 2000).

A pluralist health sector is characterised by the co-existence of public and private health providers, with some being outside the formal health care sector and practising alternative and complementary approaches to counselling and healing (Gureje, Nortje, Makanjuola, Oladeji, Seedat, & Jenkins, 2015). Faith-based organisations, particularly the Christian clergy, have been recognized as important stakeholders in the composition of pluralistic health systems for BME and other African minority groups (Knifton, Gervais, Newbigging, Mirza, Quinn, Wilson, & Hunkins-Hutchison, 2010; Shefer, Rose, Nellums, Thornicroft, Henderson, & Evans-Lacko, 2012). The international scholarship has recognised clergy from various ethnicities and religious denominations as *frontline mental health workers* (Oppenheimer et al., 2004), a *community mental health resource* (Payne, 2009), *community mental health allies* (Yamada, Lee, & Kim, 2012), and as *gatekeepers* to mental health and substance abuse services (Chalfant, Heller, & Roberts, 1990; VanderWaal, Hernandez, & Sandman, 2012). Beyond that of religious providers, clergy’s roles have been shown to include encouraging healthy behaviours, performing religious rituals around life events and illnesses, advocating for cultural sensitivity in hospitals and helping church-goers with clinical decision-making, in addition to signposting and awareness-raising (Payne, 2009).

The interface between religious provision and health care provision has received increasing attention from researchers, mental health professionals and policy-makers for its significance for bridging the ethnic divide in mental health outcomes (NHS Health Scotland, 2014; Leavey, Dura-Vila, & King, 2012; Royal College of Psychiatrists, 2013). In this paper, we argue that exploring clergy’s *mental health literacy* (Jorm et al., 1997) may offer revealing insights into the nature of pastoral support they provide for the mental health needs of congregants, into clergy’s referral tendencies, and into clergy’s their willingness and readiness to collaborate with formal health professionals. A dimensional concept, mental health literacy denotes knowledge about how to identify, treat and prevent mental disorders; knowledge about help-seeking and treatment options available, awareness of self-management strategies, and the skills to support an individual affected by a mental health problem (Jorm et al., 1997; Jorm et al., 2015).

The scarce empirical literature on the mental health literacy in African-American and BME clergy has illuminated some of the interrelations among the structure and effectiveness of pastoral counselling, explanatory models of illness and the clergy’s socio-cultural contexts. Overall, some of the persistent points of divergence in findings have concerned: the espoused explanatory model (that is, aetiological attributions) of mental illness; the degree in clergy’s confidence in addressing the mental health difficulties in their congregants’; and the espoused tendency to make a referral to a (mental) health professional.

To demonstrate, Stansbury and Schumacher’s (2008) conducted a qualitative descriptive investigation of the mental health literacy and pastoral counselling practices of nine elderly African-American clergy. The interviewed clergy were committed to caring for the holistic needs of the congregants, as part of their faith community milieu. The clergy’s pastoral responses differed, however, according to the clergy’s perceived severity of the congregant’s socio-emotional problems. While lower-intensity psychological distress was primarily address with religious interventions such as scripture readings, and with self-help interventions such as prayer, higher-intensity psychological distress was typically responded to with an external referral. Interestingly, while the clergy believed faith and religiosity offered *‘an infallible source of comfort’* (p. 134), they recognised the necessity of medication for mental illness, in certain instances. Stansbury and Schumacher’s study does not offer a critical analysis of the possible tensions between spiritual interventions and medical interventions, and about the ways in which the clergy reconcile those seemingly disparate philosophies of care. Another limitation of their study is that the participants were queried about their pastoral practices and beliefs in generic terms as opposed to specific constellations of socio-emotional problems as demonstrated by case vignettes methodologies (e.g. Brown-Hughes, Harley, & Stansbury, 2009). Finally, this study, along with several follow-up investigations (Stansbury, 2011; Stansbury, Bleecher, & Clute, 2011), only focused on clergy’s mental health literacy in relation to their elderly congregants thus further limiting the transferability of the findings.

Larger, survey-based quantitative studies have also made an important contribution to understanding the structure of pastoral counselling in relation to congregants’ mental and holistic well-being. Utilising an ethnically diverse and multi-denominational sample of 173 (22 (13%) Black/African American) Michigan-based clergy, VanderWaal and colleagues (2012) examined ethnic differences in pastoral practices. Particularly, their statistical analyses found that the African American pastors were significantly more likely to encounter issues of interpersonal violence and substance abuse than their Caucasian counterparts. Also, the African American pastors were found to be significantly *less* likely to make a referral to a helping professional for marital issues and for depression than the other surveyed ethnic groups. Overall, however, the respondents’ stated referral tendencies were high. Across ethnic groups, the respondents favoured professional, including medical, help for serious mental health challenges and criticized the helpfulness of ‘*narrow spiritual solutions’* in those circumstances (p. 47). Those findings are somewhat at odds with the results from Payne’s (2009) survey study with 204 California-based Protestant pastors (133 Caucasian American, 51 African American/Black, 20 other). Specifically, the Caucasian pastors were found to be more likely than the African American pastors to agree with a biological definition of depression, while the opposite pattern was observed for a spiritual definition of depression.

VanderWaal and colleagues (2012) highlight that clergy’s beliefs about the causation of mental health problems are invariably complex, with possible interactions among spiritual, biological and socio-cultural factors. Survey-based research designs are arguably limited it their ability to shed light onto the intricacies and relevant contexts pertaining to explanatory models of mental distress.

The scant UK-based qualitative research into Christian clergy’s pastoral practices and mental health related beliefs has been mostly associated with the work of Gerard Leavey (e.g. Leavey, 2008). In a 2008 interview-based qualitative study with 32 clergy from different religions, denominations and ethnic backgrounds, of whom seven Black Africans and two Afro-Caribbeans, Leavey examined clergy’s pastoral care practices in relation to the congregants’ psychological concerns. Several findings pertaining to the Christian respondents’ mental health related beliefs are noteworthy. While the mainstream Christian clergy avoided espousing religious or spiritual interventions as a standalone treatment for serious psychological distress, they did advocate for spiritual care and prayer as valuable for promoting religious coping, acceptance of mental illness in one’s life, as well as identity transformation. The Pentecostal clergy more openly discussed spiritual practices such as spiritual reclamation and deliverance. Those respondents did believe that certain types of mental illness had biological causes; however, they commented on the inability of medical interventions to access the spiritual dimension of suffering. Leavey’s (2008) findings were disaggregated by religion rather than ethnic group so the findings cannot be fully extrapolated to the BME religious community.

Commonly, clergy who identify a mental health problem as exclusively spiritual in origin have shown tendencies to exclusively rely on self-counsel, offer Biblical guidance and use scriptures, and perform formal religious ceremonies such as deliverance and exorcism rituals to treat the problem, which could lead to delays in their congregants’ reaching professional psychiatric help (Brown-Hughes et al., 2009; Leavey et al, 2012; Swanson et al., 2004).

Importantly, numerous studies have identified gaps in the preparedness of clergy to address the mental health needs of their congregants in terms of inadequate problem-specific knowledge and skills (for instance, training for suicidal risk (Mason et al., 2011), post-traumatic stress disorder (Chevalier et al., 2015), emotional problems, substance use problems and family issues (Brown & McCreary, 2014), limited awareness of psychotherapeutic aids (Brown-Hughes et al., 2009), and insufficient educational experience such as counselling training to equip them to handle those issues in accordance with evidence-based practice (Bledsoe & Adams, 2011; Anthony, Johnson, & Schafer, 2015).

## Context and objectives of the current study

The African population in Scotland had a five-fold growth between 2001 and 2011, with Glasgow (Scotland’s most populous city) currently having the highest proportion of African residents (Scotland’s Census, 2011). The Scottish Government has stated a strong commitment to providing equitable care to diverse ethnic groups via adopting and implementing equality and non-discrimination legislation, via the routine monitoring of health surveillance and equalities data, and via stimulating research on the health of ethnic minorities in Scotland (NHS Health Scotland, 2014). To respond effectively to the changing ethnic composition of Scotland and to provide equitable, culturally competent health care, NHS Health Scotland (2014) has strongly emphasized the importance of acknowledging the significant role of religious and cultural beliefs in help-seeking and outcomes pertaining to mental health and well-being, as well as the need to further investigate the pathways (formal and informal) by which individuals from ethnic minority groups access mental health care and treatment.

Although clergy’s multistrand involvement in their communities has been long-established (Haugk, 1976; Moreira-Almeida et al., 2006, for a review), no in-depth processual accounts of the nature of pastoral support and mental health literacy of the Christian clergy in Scotland have been conducted to date. The quality of mental health support that clergy offer has been shown to be linked to their ability to recognise the sign and symptoms of mental health problems, in addition to their perceptions of their aetiology (explanatory models; Taylor et al., 2000). Furthermore, clergy’s mental health related beliefs have been shown to be indicative of their willingness to collaborate with formal health professionals (Stansbury et al., 2011; Dura-Vila & King, 2012). Clergy’s conceptualisation of mental health problems, therefore, seems crucial the understanding of the utilisation and effectiveness of pastoral support in the context congregants’ mental welfare.

The specific aims of the current exploratory, qualitative-descriptive study are to explore the various aspects of the mental health literacy (Jorm et al., 1997) of Glasgow-based Christian clergy leading predominantly BME congregations. Specifically, the current study aims to elicit information about the clergy’s:

(1) Ability to recognise specific disorders or different types of psychological distress;

(2) Knowledge and beliefs about risk factors and causes;

(3) Knowledge and beliefs about self-help interventions;

(4) Knowledge and beliefs about professional assistance available;

(5) Attitudes facilitating recognition and appropriate help-seeking;

(6) Knowledge of how to seek mental health information.

# Beyond the mental health literacy framework, this study investigated the role of the clergy and the Christian Church in their congregants’ lives, in addition to the clergy’s attitudes towards collaborating with (mental) health professionals.

# Method

## *Design and materials*

A qualitative descriptive design (Sandelowski, 2000) was used. Specifically, data were analysed using content analysis (CA). According to Vaismoradi, Turunen and Bondas (2013), CA is well-equipped to represent and analyse multifaceted and sensitive phenomena especially in research domains that are relatively underresearched.

A semi-structured interview schedule, lasting between 1-1.5 hours was administered by the first author. The first half of the schedule contained questions organised into the following sections: (a) details about the church, clergy hierarchy and congregation; (b) any church activities focused around congregants’ health/mental health; (c) whether congregants seek advice from the clergy about socio-emotional or psychological problems (e.g. *How often do your congregants seek personal advice/individual consultation/counselling from yourself?; What are the most common problems you are presented with during those individual counselling/advice sessions?*); (d) clergy’s perception of the general role of the church in the lives of the congregants, specifically those experiencing psychological distress; (e) nature of the pastoral support that they provide (e.g*. If you are approached for help with psychological distress, to what extent do you feel that you are able to provide assistance?; What does it mean to you to be a provider of the spiritual and emotional needs of individuals seeking help?);* and (f) awareness of professional services available for mental health problems, referral practices and dispositions, and attitudes towards collaboration with formal health practitioners.

In the second half of the interviews, participants were presented with three case vignettes (one at a time) depicting depression with suicidal thoughts (Scenario One), stress or mild depression and/or anxiety accompanied by somatic symptoms (Scenario Two), and early schizophrenia (Scenario Three), respectively (See ‘Figure 1’). The vignettes had been validated by a sample of clinicians indicating the symptom depictions matched the intended diagnoses (Reavley & Jorm, 2011; Lloyd, Jacob, Patel, Louis, Bhugra & Mann, 1998; Prior, Lewis, Wood & Pill, 2003). The scenarios were chosen to represent a common mental health problem (Scenario One), a serious mental illness (Scenario Three) and purposefully ambiguous subclinical symptomatology mixed with somatic complaints (Scenario Two). It was therefore hoped that the depicted scenarios would elicit various causal attributions. All vignettes were used with the authors’ explicit permission.

*Scenario One: Depression with Suicidal Thoughts*

Jenny is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Jenny doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Jenny's boss who is concerned about her lowered productivity. Jenny feels she will never be happy again and believes her family would be better off without her. Jenny has been so desperate, she has been thinking of ways to end her life.

*Scenario Two: Stress or Mild Depression and/or Anxiety Accompanied by Somatic Symptoms*

Mr Edwards, a 38-year-old factory worker married with two children, has been feeling tired, irritable and lacking energy for about three months. There has been a lot of uncertainty about the future of the company he works for. He has trouble getting to sleep and has chronic backache, stomach pains and aching legs. This has affected his ability to care for his children and enjoy their company. He prefers to sit around the house watching television.

*Scenario Three: Early Schizophrenia*

John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realize he is not taking drugs because he never sees anyone or goes anywhere.

Figure 1: *Case study vignettes (Adapted from Reavley & Jorm (2011) and Lloyd et al. (1998). Note: Participants were not showed the diagnostic descriptions of the vignettes.*

The participants were given time to familiarise themselves with the case vignettes, after which they were asked several follow-up questions: *What, if anything, would you say is wrong with…?; What do you think might be the possible causes of their situation?; How do you think…could be helped best?; What people and what kinds of help do you think would be most appropriate and helpful for…?; Have you, in your professional practice, been approached by a congregant with similar concerns? If yes, what was the outcome?; In your opinion and judging from your experience, what do you think would be the most likely outcome for…if they sought professional help?; And what would the most likely outcome be if they didn’t seek any professional help?; What problems, if any, do you think ….would encounter while seeking help for their problem?; What difficulties do you run into in making referrals?; What hesitations do you have?; What difficulties exist in the community?; If you do, at what point would you refer out to a mental health professional or a GP?*

The questions accompanying the vignettes were obtained from Reavley and Jorm’s (2011) Australian National Survey of Mental Health Literacy and Stigma.

## *Participants and sampling strategy*

Maximum variation (purposive) sampling (Patton, 2002) was employed to recruit a sample representing a heterogeneity of church demographics (e.g. denominational membership, size, clergy structure) as well as clergy demographics (e.g. age, gender, ethnicity, secular education, level of pastoral training). The maximum variation sampling technique is useful for capturing significant shared patterns of the phenomenon under enquiry as manifested across contexts (Patton, 2002).

The main recruitment methods were personal communication, use of key informants and snowballing. To be eligible for inclusion, participants had to be ordained clergy members in a Christian faith-based organisation in Glasgow. Participants had to have at least 50 BME church members as part of their congregations. Visiting clergy, non-ordained worship leaders, pastor assistants and non-English speaking clergy were not eligible for participation.

Ten Glasgow-based Christian clergy (including eight pastors, one bishop and one parish priest) were included in the current study (See ‘Table 1’). All but one participant were male. The sample represents four denominations (Pentecostal (7), Independent (1), Catholic (1), Seventh-Day Adventist (1), and two ethnicities (African or Black (8 Nigerian and 1 Eritrean) and Mixed Caribbean (1 Jamaican). Their ages ranged from 38 to 64 years (Median age = 52 years; interquartile range (IQR) = 10). Collectively, the respondents reported that they served more than 1200 congregants, of whom approximately 800 (65-70%) were from BME groups.

Table 1: *Clergy Characteristics*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clergy member | Age\* | Sex | Ethnicity(Self-identified) | Clergy role | Tenure | Membership size (% BME)\*\* |
| Pastor A | 50-55 | Male | Black British | Pastor | 10 years | 150-200 (60%) |
| Pastor B | 50-55 | Male | African  | Bishop | > 9 years | 50-100 (85%) |
| Pastor C | 50-55 | Female | Black British  | Minister | 3 years | 50-100 (80%) |
| Pastor D | 35-40 | Male | African | Pastor | 9 years | 100-150 (99%) |
| Pastor E | 40-45 | Male | African  | Pastor | 9 years | 50-100 (100%) |
| Pastor F | 50-55 | Male | African British  | Pastor | 8 years | 100-150 (95%) |
| Pastor G | 60-65 | Male | Black | Pastor | 10 years | 50-100 (99%) |
| Pastor H | 50-55 | Male | African | Pastor | 10 years | 100-150 (75%) |
| Pastor I | 45-50 | Male | African | Parish priest | 7 months | 250-300 (n/a\*\*\*) |
| Pastor J | 40-45 | Male | Mixed Caribbean | Minister | 2.5 years | 100-150 (70%) |
|  |  |  |  |  |  |  |

\*The exact age has been concealed for anonymity purposes.

\*\*The exact congregation size has been concealed for anonymity purposes.

\*\*\*Information was not obtained.

## *Procedure*

Initially, 29 Christian churches (15 Pentecostal, six Independent, two Adventist, two Catholic, three Methodist and one Orthodox) were invited to the study by email. Reasons for non-participation included no response (11), unavailability of the clergy due to increased workload or annual leave (5), lack of resident clergy (2) and lack of interest (1). One-hour individual in-depth interviews were conducted with the ten clergy who agreed to participate. Interviews were audiotaped and interview transcripts were pseudoanonymised for confidentiality. Respondents were contacted four weeks’ post-interview for additional feedback.

The data collection was carried out by the first author between April and July 2016. The authors used their a-priori knowledge of the topical literature, in conjunction with the concepts of *data variability* and *data richness* in qualitative research (Fusch & Ness, 2015), to operationalise and assess for (thematic) data saturation (the point when *‘new categories, themes or explanations stop emerging from the data’* (Marshall, 1996, p. 523). Collectively, data variability and data richness characterise the degree to which the accumulating data are ‘*many-layered, intricate, detailed*, *nuanced*’ (Fusch & Ness, 2015, p. 1409). After ten interviews, after initial reading and re-reading of the interview transcripts, it was noted that multiple nuanced explanatory models of mental distress emerged including psychological, spiritual, biological and socio-economic, were exemplified. Furthermore, varied roles of the clergy were discussed in terms of individual counselling, marriage counselling, clinical counselling and others. Conflicting views also started to emerge, for instance, in terms of the respondents’ dispositions towards collaborating with health professionals and in terms of prognosis following symptoms of psychosis. Those emerging data patterns were taken as indicators of adequate data variability (Guest, Bunce, & Johnson, 2006), in the context of the aims and objectives of this descriptive, exploratory study. Thus, after ten interviews, data saturation was deemed reached.

## *Rigour checking and trustworthiness*

The Consolidated criteria for reporting qualitative research (COREQ; Tong, Sainsbury, & Craig, 2007) were followed to ensure the trustworthiness and transparency of the analysis.

The data analysis was conducted by the first author. An independent mental health researcher was familiarised with the MHL framework and asked to co-code a random selection of 50% of the anonymised transcripts. No substantially different codes or categories emerged from this second content analysis. The second author commented on the preliminary data analysis to ensure consistency of the deductive application of the MHL framework, as well as closeness of the analysis to the original data (Sandelowski, 2000).

*Member checking* was conducted four weeks post-interview as a verification technique to ensure that the findings are grounded in the data and are not heavily influenced by researcher bias, and thus to enhance the credibility of the findings (Shenton, 2004). The respondents were sent the following post-interview feedback questions via e-mail: *What are your thoughts about how the questions that the interviewer asked during the interview (e.g. in terms of relevance and appropriateness)?; What are your views of the overall relevance of the research topic that is the focus of this study?; Has taking part in this study made you view and/or reflect on your role as a clergy member serving the local community any differently?; Is there anything you did not manage to say during the interview but would like to add regarding the topics covered in the interview?.* In addition, the respondents were asked to briefly comment on a narrative summary of the anonymised findings.

The response rate was 50%. Those five respondents agreed with the final analysis and offered positive feedback on their interview experience and on the significance of the research topic.

## ***Data analysis***

CA combining inductive and deductive coding was used (Hsieh & Shannon, 2005; Vaismoradi et al., 2013). The analysis followed a four-stage process (Boyatzis, 1998; Crabtree & Miller, 1999) and was implemented by the first author: (1) inductive (data-driven) coding for manifest content; (2) refinement and organisation of codes into sub-categories based on conceptual closeness; (3) application of the MHL framework components as a template to organise the sub-categories into higher-order categories (directed content analysis; Hsieh & Shannon, 2005); and (4) corroborating and legitimating codes, sub-categories and categories (See ‘Table 4’).

Because MHL was used to organise the semi-structured interviews, the bulk of the qualitative data mapped neatly onto the six MHL components (See ‘*Context and objectives of the current study’;* See ‘Table 4’). To appropriately connect the emergent codes and sub-categories to the MHL framework components, the first author used Jorm’s operationalisation of each of the MHL components (Jorm et al., 1997; Jorm, 2012). For instance, Jorm and colleagues (1997) defined self-help interventions as *‘…actions that a person can take on his or her own to deal with a mental disorder. Sometimes self-help strategies are used under the guidance of a health professional as part of psychological therapy. However, more often these are used informally without any professional guidance…’* (p. 234). Following this definition, it was determined that ‘*reflection*’ and *‘self-analysis’* (inductive codes) belonged to this category.

Directed CA still allows for the analysis to be extended in order to accommodate all data units that are deemed significant- even those which are not consistent with the conceptual framework guiding the data categorization (Hsieh & Shannon, 2005). Any data that could not be categorized with the initial coding scheme were organised into new (emergent) categories. As a result, additional categories emerged (e.g. Role(s) of clergy and the Christian Church and Characteristics of pastoral support; See ‘Table 4’). The abstraction process continued until all significant content was accounted for, in accordance with the research questions.

## *Ethical clearance*

# Ethics approval was granted by the University of Glasgow’s College of Medical, Veterinary & Life Sciences Ethics Committee (Project No. 200,150,110).

# Results

## *Individual characteristics and pastoral experience of the clergy*

Apart from key demographic characteristics (age, sex, ethnic group, etc.) presented in ‘Table 1’, The Clergy Questionnaire yielded information on the respondents’ secular and theological educational background, faith-based organisation and pastoral experience (See ‘Table 2’).

Table 2: *Educational background and role characteristics of the clergy (N =10)*

|  |  |
| --- | --- |
|  | N (%) |
| Clergy structure (total number of clergy members in each church)OneOne-FiveFive+ | 2 (20)6 (60)2 (20) |
| Hours per week worked in ministry10-2020-3535+ | 2 (20)1 (10)7 (70) |
| Level of secular educationSome college, less than BA/BSSecular bachelor’s degreeSecular master’s degreeSecular doctoral degree | 3 (30)3 (30)1 (10)3 (30) |
| Area of secular educationLawBiomedical and life sciencesEngineering | 1 (10)5 (50)1 (10) |
| Had counselling or mental health related trainingYesNo | 8 (80)2 (20) |
| Had offered counselling for mental health problemsYesNo | 5 (50)5 (50) |

The respondents were also asked the areas in which they had offered pastoral support from a comprehensive list of issues (See ‘Table 3’)*.*

Table 3: *Clergy questionnaire responses: Areas pastoral support offered in (N = 10)*

|  |  |
| --- | --- |
| Areas pastoral support offered in | Proportion |
| Premarital | 90% |
| Marital  | 90% |
| Bereavement  | 80% |
| Family violence  | 80% |
| Food assistance | 80% |
| Housing | 70% |
| Divorce  | 70% |
| Individual | 70% |
| Hospital visitationUnemploymentFinancialLegal problemsGrief | 70%70%70%70%70% |
| Child behavioural problems  | 60% |
| Adolescent behavioural problems  | 60% |
| Discrimination  | 60% |
| Depression  | 50% |
| Substance abuseIntimate partner violenceAddictionGay and lesbian | 40%40%30%20% |
| Prison ministry | 10% |
| Gang activity | 10% |

Table 4: *Summary of the qualitative content analysis of the semi-structured interview data.*

|  |  |  |  |
| --- | --- | --- | --- |
| Research question | Category | Sub-category | Exemplary codes |
| Role(s) of clergy and characteristics of pastoral support | Role(s) of clergy and the Christian Church | Practical support | Financial help, food assistance, information and sign-posting |
| Spiritual support | Bible-based advice, scripture-guided support |
| Social support | Help with marital issues |
| Moral compass | Model for good citizenship, model for correct living |
| Characteristics of pastoral support | Personal attributes and skills for effective pastoral support | Empathy, non-judgemental, ‘gift of discernment’ |
| Emotional burden of pastoral support | Workload, burden, sources of coping |
| Delimitations of the pastoral role | Unrealistic expectations of some congregants, ‘advisor’, not ‘counsellor’ |
| Mental health literacy | Conceptualisation of psychological distress | Depression with suicidal thoughts | Depression, trauma, emotional instability |
| Mild depression and anxiety in the context of a life stressor and somatic symptoms | Uncertainty, worry |
| Early schizophrenia | Psychosis, paranoia |
| Aetiological attributions of psychological distress | Environmental causes | Work, parenting styles |
| Psychological causes | Pessimism, overthinking |
| Biological causes | Dopamine deficiency |
| Spiritual and supernatural causes | Spiritual attacks, the devil |
| Religiosity and faith | Scriptures, prayer, Bible, God |
| Knowledge and beliefs about self-help interventions | Social network | Family, church fellowship |
| Self-efficacy | Self-belief, courage |
| Reflection | Self-analysis |
| Referral tendencies | You’d better make a referral |
| Knowledge and beliefs about professional assistance available | GPs and mental health specialists | Effective, not solved by medical attention |
| Other specialised external help | Christian counselling |
| Accessibility of health services | Accessible, stigma, lack of empathy |
|  | Engagement, willingness to receive help |
| Attitudes facilitating recognition and appropriate help-seeking |  | Community awareness |
| Fellow church members |
| Knowledge of how to seek mental health information | Experience of clergy-practitioner partnerships | Academic resources |
| Willingness to learn |
| Worked with case workers |
| Attitudes towards collaborating with (mental) health professionals | Attitudes towards collaborating with (mental) health professionals | Proponents of collaboration | Mutual work |
| Barriers to collaboration | Health professionals are sceptical  |

## *Themes generated by the qualitative content analysis of the in-depth interviews*

*Role of the clergy. Role of the Christian Church*

Collectively, the respondents’ accounts demonstrated the multifaceted role of the Christian Church in the lives of the congregants in terms of providing practical support (i.e. financial help, food help, information and professional advice), spiritual guidance (i.e. ‘Bible-based advice’, ‘scripture-guided support’) and social support. According to the respondents, the church offered a model for good citizenship, as well as instruction for a social and marital life in accordance with moral, cultural and religious norms (See ‘Table 4’).

The role of the Christian Church in meeting the multiple needs of the worshipper was succinctly summarised by Pastor B: ‘*To the African community, to the average African Christian, the church is everything. The pastor is seen as a doctor, their counsellor, the financial advisor, a mental health expert, a parenting expert...’.*

*Personal attributes and skills for effective pastoral support*

Respondents identified several vital ingredients of effective pastoral counselling: empathising, listening and understanding, together with being non-judgemental and non-directive. Two of the respondents, Pastor E and Pastor C, also openly discussed their confidence in their supernatural abilities granted by God, namely the *‘gift of discernment’* and the *‘revelation of the Word’*. According to the respondents, because of those personal attributes and because of the cohesiveness of the church community, they were in a favourable position to detect early warning signs of psychological distress, namely social withdrawal, detachment, denial and other abnormal behaviour, in their congregants.

*Emotional burden of pastoral support*

Generally, the respondents demonstrated an awareness of the potential danger of the emotional burden of providing pastoral support. One respondent shared a detailed account of how his workload often interfered with his family life. Their sources of coping included God, the Bible, their family as well as peer support.

*Delimitations of the pastoral role*

Virtually all respondents delineated their role as being that of religious providers and not health professionals and that of advisors and not counsellors. In contrast, according to Pastor B, the role boundaries of clergy in Africa tended to be less well-defined:

*If you are a pastor in Africa, and you have this notion that you can solve all people’s problems, all the problems…And you get to the point when you become a victim… trying to help people and they cross the line.*

## Finally, Pastor J expressed the concern that congregants sometimes had unrealistic expectations about the pastor’s ability to provide a solution to any problem they presented them with.

## *Conceptualisation of psychological distress*

This category reflects the respondents’ conceptualisation of the psychological distress exemplified in the three scenarios, typically in response to questions such as ‘*What, if anything, would you say is wrong with…?’.*

*Scenario One: Depression with suicidal thoughts*. Accurate recognition of depression occurred in 40% of the clergy. One of those respondents, Pastor B, noted that while in Africa, such an individual would be perceived as ‘*berserk*’, the education the respondent had received in the United Kingdom had enabled him to instead identify the manifestation as a mental health condition.

Forty percent of the remaining respondents only identified an extreme affective response (e.g. ‘*meltdown*’), and 20% were not able to identify a discernible psychological problem.

*Scenario Two: Stress or mild depression and/or anxiety accompanied by somatic symptoms.* The vast majority of respondents (80%) framed the problem as stress-related (employment uncertainty). Half of those respondents recognised the possibility of a depressive state. 20% of respondents did not identify a discernible psychological problem.

*Scenario Three: Early schizophrenia.*Thirty percent of the respondents attributed the symptoms to schizophrenia, 10%-to paranoia, 10%-to ‘*premonition*’ and ‘*the beginning of psycho-dementia*’. The remaining 40% did not identify a psychopathological condition.

*Aetiological attributions of psychological distress*

This category reflects the respondents’ aetiological attributions of the psychological distress exemplified in the three scenarios, typically in response to questions such as ‘*What do you think might be the possible causes of their situation?’.*

*Scenario One: Depression with suicidal thoughts.*Half of the respondents proposed the confluence of environmental (e.g. triggering life events), interpersonal (e.g. marital issues) and psychological (e.g. low self-esteem) factors as candidate causes. Of those respondents, Pastor C offered an explanatory account integrating spiritual and psychological factors:

*…the devil is able to fire negative thoughts in your heart when you are isolated…When they isolate themselves, they are able to think and project images that are not true. And that’s when they get the idea that they should go and die…*

Of the remaining respondents, three (30%) suggested a biological (somatic) cause (e.g. sleep disturbance), while two (20%) could not formulate a concrete causal mechanism.

Notably, one respondent, Pastor H, probed into whether the person depicted in the vignette was a believer and asserted: *‘Life without Christ is full of crises’*. It remains unclear whether that respondent believed that the root problem might be *spiritual* (e.g. the lack of faith in God).

*Scenario Two: Stress or mild depression and/or anxiety accompanied by somatic symptoms.* The most widely espoused causal factors tended to be socio-economic(e.g. employment uncertainty) and psychological (e.g. negative thinking cycles). Only two respondents proposed a psychosomatic causal mechanism: ‘*Stomach ache, stomach pains-that’s with nerves. Nervous activity goes down to the stomach…’* (Pastor C); ‘*Your psychological status affects your nervous system. Your nervous system goes to affect your general health.’* (Pastor F).

*Scenario Three: Early schizophrenia.*The discussion of this vignette yielded the widest range of causal attributions and showed the respondents’ considerable uncertainty as to the most likely cause. Proposed risk factors included environmental (e.g. a dysfunctional family environment; bullying), lifestyle (e.g. alcohol-, drugs- and/or gang-related), and psychological[e.g. internalised feelings of worthlessness (*‘I’m not good enough’*); disappointment] variables.

One respondent, Pastor C, asserted that biological processes, specifically a chemical imbalance in the brain,caused the behavioural symptoms. When questioned about what could have triggered those neurochemical abnormalities, Pastor C shared an anecdote about an acquaintance of hers experiencing physical maltreatment:

 ‘*And they took him…you know there are different churches…in Africa…that do weird stuff. He said they would beat him to deliver the demon out of him. They would tie him down…So I think that really messed up his mind.’*

*Knowledge and beliefs about self-help interventions*

In response to the problems presented in the three vignettes, along with professional help, the respondents consistently recommended seeking informal sources of support (familial support, engagement with the church community), nurturing one’s faith, practising religious (e.g. prayer) and meditation-based (e.g. reflection and self-awareness) rituals, and strengthening one’s self-efficacy, self-responsibility and courage. Faith, in particular, was conceptualised as ‘*a holistic approach to virtually all human problems*’ (Pastor B), as ‘*spiritual upliftment’* (Pastor F) and as a source of inspiration and empowerment.

Notably, the respondents’ views diverged regarding the extent to which faith and religious rituals (most commonly prayer) could be practised as stand-alone interventions for socio-emotional problems, and regarding the extent to which those religious interventions were compatible with formal (allopathic) treatment. A minority or respondents perceived medical interventions as inadequate for full recovery and asserted that the healing power of God was critical to treating both physical and socio-emotional problems: ‘*God is a master-surgeon.*’; ‘*The moment I pray with him, God will heal him from all these infirmities*.’ (Pastor H). ‘…*Because often most psychological distress…are not solved by medical attention. You need spiritual help.’* (Pastor F).

While Pastor C argued for the utility of both medical and spiritual interventions for socio-emotional problems, she distinguished between the function of those two intervention modalities. According to Pastor C, medical interventions (personified by ‘the doctor’) can ameliorate the symptoms or manifestations of the condition, whereas spiritual and/or pastoral interventions (personified by ‘the pastor’) address the primary cause or aetiology of the condition: ‘*Because you see…doctor would treat the symptoms…but the pastor of the congregation can treat the root. And when you find the root and is taken away, Jenny can have her life back.’*

## *Knowledge and beliefs about professional assistance available*

*Referral tendencies.* Ninety percent of the respondents stated a referral intention for Scenario One, with 70% indicating that for Scenario Two and Scenario Three respectively. Across the three scenarios, symptoms indicating the need for a professional referral were suicidality, hallucinations and delusions, suspected abnormalities of brain physiology and the chronic nature of the problems.

*General practitioners (GPs) and mental health specialists.* Overall, the respondents expressed trust in the expertise of health professionals (*‘That’s why we send our children to university’* (Pastor B), recognised their role as ‘gatekeepers’ within the National Health Service (NHS), and reported positive personal experiences as recipients of NHS care. The clergy demonstrated knowledge about both secular (psychologists, professional counsellors, psychiatrists and psychoanalysts) and religious (Christian counsellors; the NHS Catholic Chaplaincy) mental health specialists. The majority of respondents, however, showed very little knowledge of the specific therapeutic approaches practised within those specialist services.

*Perceptions of the accessibility of health services.* The majority of respondents believed that the NHS was equally accessible to all ethnicities. Simultaneously, some respondents highlighted several barriers to factors that were hindering professional help-seeking including double social stigma (based on ethnic minority status *and* on experiencing mental illness: *‘You have to push aside all those barriers, all this segregation, all this discrimination…’* (Pastor F), inadequate mental health literacy of health care personnel and help-seekers’ (false) perceptions of administrative and legal hurdles.

## *Attitudes which facilitate recognition and appropriate help-seeking*

Self-awareness, challenging denial and ‘*active engagement*’ were collectively identified as conducive to prompt and appropriate help-seeking. Pastor B, specifically, conceptualised *active engagement* as open communication, cooperation and disclosure between the congregant and the clergy member.

Several respondents advocated for increasing community awareness of mental health difficulties in order to encourage help-seeking and reduce mental health stigma. In particular, Pastor A recommended a grassroots-level approach to awareness-raising and attitudinal change, in which he saw spiritual and other community leaders as the key catalysts: *‘…there needs to be discussional engagement and education…For the community…it always starts from a grassroots level.’*

## *Knowledge of how to seek mental health information*

The most commonly relied upon source of mental health information were social networks (especially church members who were also medical professionals). Less frequently, respondents consulted academic resources on mental health. Two respondents, Pastor G and Pastor I, expressed a willingness to expand their knowledge on mental health: *‘If there are opportunities for workshops or seminars, yes, I will be interested*.’ (Pastor I); ‘*Yes, that would be very good, yes. It is part of counselling.’* (Pastor G).

## *Attitudes towards collaborating with (mental) health professionals*

*Experience of clergy-practitioner partnerships.* 50% of the respondents had had experience of collaborating with health professionals (including mental health case workers) and/or social workers to support church members who were also outpatients.

*Proponents of clergy-practitioner partnerships.* The majority of respondents held generally positive attitudes towards such collaborations. Pastor A advocated for a collaborative, multidisciplinary approach to helping individuals with socio-emotional problems based on the principles of beneficence and pragmatism (*‘Whatever the person may need to help them…*’). This respondent also emphasised the importance of realising the limitations of one’s individual area of expertise: *‘We don’t have all the answers. And no one single answer fits every question. That has to be the case. And if health professionals are sensitive to that and the pastoral…also conscious of that…we can work mutually well together.’*

*Barriers to clergy-practitioner partnerships.* Respondents alsopointed out the need for more inclusive health policies that allow for religious leaders to deliver prayers and support for inpatients if requested. One barrier (identified by Pastor G and Pastor J) was health professionals’ and policy makers’ scepticism towards the importance of faith and spirituality for one’s holistic well-being.

# Discussion

The current study built on previous qualitative work (Brown-Hughes et al. (2009); Stansbury & Schumacher (2008) by comprehensively examining the mental health literacy of UK-based Christian clergy in the context of congregations composed primarily of BME groups. The current findings are consistent with Payne’s (2009) and Chalfant et al.’s (1990) conceptualisation of clergy as a ‘community mental health resource’ and as gatekeepers to mental health services, and with other studies that have demonstrated clergy’s knowledge of a wide range of symptoms of psychological distress (Mathews, 2011; Stansbury, 2011). However, conceptualising the current study’s participants as ‘mental health providers’ or as ‘frontline mental health workers’ (Oppenheimer et al., 2004; Payne, 2009) would be both inaccurate and misleading because our participants (a) rarely perceived mental health as separate from other dimensions of well-being, and (b) demonstrated an acute awareness of the boundaries of their role. Instead, the respondents defined their role as providers of frontline holistic, low-intensity, often non-directive, empathy-based pastoral care and guidance, and expressed a commitment to serve members of their congregations in a prompt, educated and professional manner.

## *Clergy’s explanatory models of psychological distress*

The majority of the respondents expressed symbiotic beliefs about the significance of socio-economic, environmental, spiritual, biological, cognitive and psychological factors for one’s (mental) wellbeing. The respondents’ tendency to accommodate diverse explanations of wellbeing could partly be due to their exposure to the westernised, Eurocentric and biopsychosocial discourse of mental health (Fitzpatrick et al., 2014; Patel, Chowdhary, Rahman, & Verdeli, 2011). Indeed, most respondents had secular tertiary education and half of them had earned degrees in a biomedical or life science (See ‘Table 1’ and ‘Table 2’). Some respondents explicitly distinguished themselves from the ‘*typical African pastor’* and cautioned that the dominant cultural and religious beliefs about psychological distress in Africa were oftentimes counterproductive to recovery.

## *Referral tendencies and attitudes towards formal health services*

Although not an eligibility criterion, nine out of the ten respondents in the current study were of African descent. The current respondents expressed referral intentions for most scenarios, which supports previous research on African-American clergy’s endorsement of the use of professional assistance for depressive symptoms (Stansbury, 2011) and on their generally positive attitudes towards seeking formal mental health services (Brown & McCreary, 2014). Importantly, the current study offers in-depth accounts of clergy’s referral behaviour, specifically of *how* the clergy identified a socio-emotional problem as a significant mental health challenge requiring professional assistance in the first place, which complements findings from larger-scale correlational studies (for example, VanderWaal et al., 2012). Specifically, the current respondents emphasised their skills and knowledge to detect early warning signs of psychological distress (i.e. social withdrawal, detachment, denial, paranoia) as being crucial to the effective management of their congregants’ socio-emotional problems by church-based religious rituals (such as prayer) *and* by making a professional referral.

## *Can clergy practices hamper the prompt seeking of appropriate help?*

Prior research has shown that certain factors such as clergy beliefs (e.g. *spiritualisation*) and their practices (e.g. low referral rates) could lead to ineffective (and in some cases, even harmful) pastoral interventions and to delayed seeking of appropriate help (Swanson et al., 2004; Leavey, 2008; Farrell & Goebert, 2009; VanderWaal et al. 2012). The current study did not produce sufficient evidence to support such conclusions. In the current sample, spirituality and faith were viewed as vital components of one’s well-being. Pastor F, for instance, held the belief that an individual who deviated from a Bible-led life was more vulnerable to *‘spiritual attacks’*, while Pastor C asserted that an individual who isolated themselves socially could become the target of ill-intentioned supernatural interference*(‘the devil’*). However, those beliefs did not seem to interfere with the other causal beliefs that the clergy held or with their stated intentions to make a referral.Dura-Vila, Hagger, Dein and Leavey (2011) even proposed that the openness to holding both religious and medical beliefs about aetiology and treatment of mental health problems might facilitate the care of individuals who are uncertain about the cause of their suffering.

## *Methodological Limitations*

The small sample size and sampling procedure [the exclusive reliance on key informants for recruitment; some denominations (such as Orthodox and Methodist) were not represented], in addition to the inherent proneness of self-report data to social desirability and recall biases (King & Bruner 2000), limit the transferability of the current results to other clergy populations. Furthermore, anecdotal data from the open-ended questions in response to the vignettes are insufficient to ascertain whether reported causal attributions and attitudes would translate into a delayed referral or into a non-referral.

## *Conceptual, practice and policy implications*

The development, implementation and routinisation of pluralistic (incorporating secular, spiritual and indigenous perspectives), culturally competent, effective and accessible mental health care requires a cross-sectoral, multi-stakeholder, grassroots approach (WHO Europe, 2016). In such as a culturally-sensitive model of health care delivery, clergy could function as *‘cultural mediators’* (WHO Europe, 2016) to help bridge the gap between BME and other ethnic minority communities and statutory health services. Cultural mediators act to bridge the cultural and linguistic differences between client and clinician and thus improve the effectiveness of health care provision (WHO Europe, 2016). The feasibility of such a model will require overcoming professional resistance towards collaborations with clergy (Dura-Vila et al., 2011), rejecting the ‘one-size-fits-all’ mentality of statutory health services and integrating medical professional expertise with indigenous knowledges.

To enhance the continuity of care, the relationships between religious services and mental health services should be founded on mutual respect and collaboration (Milstein et al., 2010; Openshaw & Harr, 2009). The equitable partnership between religious providers and health providers can yield mutual knowledge gains in addition to other positive outcomes in the practice of both clergy and health professionals. For example, some of the current respondents demonstrated limited knowledge of specific psychotherapeutic aids utilised in allopathic health care. This seeming gap in the current clergy’s knowledge of specialised professional mental health interventions might reveal promising foci for workshops, multi-stakeholder forums and community awareness-raising events focused on BME groups, for instance, and co-facilitated by religious providers and health providers (Hankerson & Weissman, 2012; Milstein et al., 2010; Mattox & Sullivan, 2008). Furthermore, previous studies have evidenced the enormous workload and emotional burden associated with clergy’s provision of pastoral support for socio-emotional problems leading to burnout, low quality of life and low job satisfaction (Jacobson, Rothschild, Mirza, & Shapiro, 2013; Kinman McFall, & Rodriguez, 2011). Those findings can provide impetus for initiatives to further empower, train and support clergy members to deliver more effective psychosocial support to their congregants (for example, *mental health first aid training* (Kitchener & Jorm, 2002), and also to more actively engage in referrals to and from health professionals (*reciprocal referrals*; Mattox & Sullivan, 2008; Milstein, Manierre, & Yali, 2010).

# Conclusion

The increasing ethnic and cultural diversity in the UK, together with the observed ethnicity-related health differentials, mandates the investigation of approaches to improve the preparedness and effectiveness of community-based organisations, particularly faith-based organisations, to address the gross unmet holistic health needs of BME and other ethnic minority groups. Health professionals and statutory organisations in general should be mindful of ‘the strategic and symbolic importance of clergy’ (Leavey et al., 2012, p. 357) in ethnic minority communities. Instead of examining how clergy and mental health professionals work separately, future studies should focus on identifying pathways to establishing and sustaining effective interdisciplinary partnerships between the two groups (Hankerson & Weissman, 2012; Openshaw & Harr, 2009). Ultimately, as Patel and colleagues (2011) incisively note, the lessons learned from developing more responsive mental health services for BME communities could also be applied to laying the foundations for better service responses not only for other ethnic communities but also for the wider population.

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