Ministers as Informal Mental Health Care Providers

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Abstract

Although not typically considered formal mental health care professionals, clergy are regularly contacted as a resource by people with mental illness. Little is known about the clergy's role in this capacity. The aim of this research is to explore the experiences and perspectives of Canadian ministers of the United Church in response to mental health issues using simple qualitative description. Three female and nine male urban ministers of the United Church of Canada were recruited to participate in semi-structured interviews. Interviews were audio recorded, transcribed, and analyzed by hand for relevant themes. Themes within the following three main topics emerged: how ministers served people with mental illness, ministers' experiences working alongside formal mental health care professionals, and remaining challenges and facilitators. Ministers reported providing various support services for people with mental illness. While ministers reported little direct collaboration, they reported regularly referring people with suspected mental illness to formal mental health care professionals**.** Finally, ministers cited an innate trustworthiness in their profession and their community as facilitators, while remaining challenges included limitations in terms of financial resources, time, trust between themselves and formal mental health care professionals, and trust between ministers and their colleagues. The findings of this research indicate that collaborative relationships should be encouraged between formal mental health care professionals and ministers of the United Church to better serve people with mental illness.

Key Words: United Church of Canada, ministers, clergy, mental health, collaboration

Résumé

N'étant généralement pas considérés comme des professionnels de la santé mentale, les membres du clergé sont régulièrement sollicités comme personnes ressources par des personnes atteintes de maladie mentale. On en connaît peu sur le rôle du clergé dans le domaine de la santé mentale. Le but de cette recherche est d'explorer les expériences et points de vue de pasteurs de l'Église Unie du Canada en réponse aux problèmes de la santé mentale à l'aide de la description qualitative simple. Trois femmes et neuf hommes pasteurs urbains de l'Église Unie du Canada ont été recrutés pour participer à des entrevues semi-structurées. Les entrevues ont été enregistrées, transcrites et analysées. Trois grands thèmes ont émergé : la façon dont les pasteurs mettent leurs services au profit des personnes atteintes de maladie mentale, l'expérience des pasteurs à travailler conjointement avec les professionnels des soins de santé mentale, et les défis restants et les mesures facilitant la prise en charge de ces personnes. Les pasteurs ont déclaré fournir divers services de soutien aux personnes atteintes de maladie mentale. Bien que les pasteurs aient signalé peu de collaboration directe des professionnels des soins de la santé mentale, ils ont déclaré leur diriger régulièrement des personnes soupçonnées d'être atteintes d'une maladie mentale. Finalement, les pasteurs ont déclaré avoir une confiance innée en leur profession et en leur communauté comme intervenants facilitateurs, bien que de nombreux défis se posent au niveau des ressources financières, du temps, de la confiance entre pasteurs et professionnels des soins de la santé mentale, ainsi que de la confiance entre les pasteurs et leurs collègues. Les résultats de cette recherche indiquent que les relations de collaboration entre les professionnels des soins de la santé mentale et les pasteurs de l'Église Unie devraient être encouragées pour mieux servir les personnes atteintes de maladie mentale.

Mots clés : Église Unie du Canada, pasteurs, clergé, santé mentale, collaboration

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Chapter 1: Introduction

Background

Historically, spirituality and health were considered so intertwined that a single professional often administered services related to both disciplines. In the mid-19th century evidence-based medicine initiated a secular approach to healing, and this approach remains the standard in western medicine today (Rosner, 2001). Although physicians report feeling uncomfortable addressing patient spirituality, research indicates that people frequently wish to have their spirituality considered in relation to their treatment (Koenig, 2004; Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Research has found that when this need is met, there tends to be a better outcome to treatment (Koenig, George, & Titus, 2004; Rosner, 2001).

Despite this evidence, recent research has demonstrated a lack of comprehensive training for formal mental health care professionals regarding the integration of client spirituality into treatment. A study found that only slightly more than 1 out of 10 directors of APA accredited programmes in clinical psychology indicated that their curriculum offered a complete course addressing religion (Brawer, Handal, Fabricatore, Roberts & Wajda-Johnston, 2002). A study of physicians' training in religion and spirituality found that much of their knowledge came from personal reading and the practice of their own faith tradition, and not from their medical school curriculum (Rasinski, Kalad, Yoon & Curlin, 2011). However, considering the diversity of the many ethnic – and hence religious – groups represented in North American society, the above approach is insufficient to the meet the needs of the culturally diverse client base in urban centers (Whitley 2009).

Clergy are often regarded as having an important role in the mental health of their community (Larson & Larson 1994; Wang, Berglund, & Kessler, 2003; Weaver, Fannelly, & Oppenheinmer, 2003). Although clergy (particularly in the Christian community) are regarded

as informal front line mental health care workers, little is known about the services they offer to people with mental illness (Jacobson, Rothschild, Mirza, & Shapiro, 2012; Kramer, Blevins, Miller, Phillips, Davis & Burris, 2007; Weaver, 1995). Indeed, clergy hold a unique place in society; they are held in high esteem, seen as trustworthy with high social skills, and often have long-standing relationships with individuals (Matthews, 2011; Weaver et al., 2003). Clergy are perhaps more accessible to people with mental illness when compared to formal mental health care professionals because many of the barriers that discourage engaging formal mental health care professionals – stigma, cost, accessibility, and a common cultural reference – are greatly diminished when seeking support from clergy (Livingston & Boyd, 2010; Oppenheimer, Flannelly, & Weaver, 2004; Vogel, Wade, & Hackler, 2007). One survey in the United States found that of those who had ever sought treatment for mental illness, approximately 25% had done so from a member of the clergy – a higher proportion than the number of people who had sought help from psychiatrists (16.7%) or general practitioners (16.7%) (Wang et al., 2003). Unfortunately similar statistics are unavailable for Canada, as most studies examining the Christian religion and mental health originate from elsewhere.

Despite a clear demand for pastoral counseling services from clergy, 50-80% of clergy feel insufficiently prepared to offer help related to mental illness (Weaver, 1995). An American survey found that of 2,000 Protestant clergy, almost all agreed that they could benefit from additional training in pastoral counseling (Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). Another study conducted focus groups with clergy and found that they considered their own lack of training to be one of the fundamental barriers to providing services to congregants suffering from mental illness (Kramer et al. 2007). A survey of 157 clergy from various denominations revealed that their knowledge of symptoms of emotional distress were roughly equivalent to that of group of college students in a first year psychology class, and was less than

that of students in graduate programmes for clinical and counseling psychology and clinical psychologists (Domino, 1990). The research outlined above indicates that there is a disconnect between the services requested of clergy and their preparedness to accommodate these requests.

While many of the barriers associated with the formal mental health care system are absent or greatly diminished when compared with accessing clergy as a resource for mental illness, clergy have described several barriers that they encounter when providing informal mental health care services. These include the limitations of their own training and knowledge, third party service accessibility for referral, financial considerations of both the individual seeking help and the church, confidentiality, social stigma, and trust between professionals (Kramer et al., 2007). Importantly, clergy also reported feeling overwhelmed by the mental health problems their congregants presented (Kramer et al., 2007). Despite these difficulties, research indicates that clergy remain unlikely to make referrals to formal mental health care professionals (Aten, 2004; Mathews, 2011; Meylink & Gorsuch 1988; Piedmont 1968). Although fewer in number than the identified barriers, some significant facilitators for clergy providing informal mental health care services were also identified. These facilitators included formal mental health professionals who were also congregants, support groups for congregants at the church, and the availability of self-help videos and books (Kramer et al., 2007).

Given the research indicating that neither clergy nor formal mental health care professionals are able to effectively address both spiritual and medical concerns simultaneously, a reasonable solution would be to develop professional collaborations between the two disciplines. Overall, the subject of collaboration between clergy and formal mental health care professionals is poorly explored, and tension between the two professions is apparent in some existing literature (Farrell & Goebert, 2008; Scheurich, 2003). An American study on family physicians found that 30% referred patients to clergy more than 10 times per year, and the

majority of these referrals were exclusively surrounding death and bereavement (Daaleman & Frey, 1998). A study examining the referral attitudes of clergy found that they were often providing support rather than referring to a formal mental health care professional, even after acknowledging their lack of training in mental health care as a potential problem. The study also reported that some clergy cited "poor collegiality" with formal mental health care professionals as a challenge (Farrell & Goebert, 2008). Older research suggests that perhaps a low referral rate from clergy is due to them not perceiving the referral relationship with the medical community as reciprocal (Piedmont, 1968). Considering the paucity of the existing research and the apparent tension between the two disciplines, encouraging the development of collaborative relationships could ultimately benefit people seeking treatment for mental illness.

Although several studies have illustrated an association between religious adherence and mental health, the formal mental health care system is largely reluctant to address religious beliefs (Bonelli & Koenig, 2013; Foskett, 2001). When formal mental health professionals neglect to address clients' religious beliefs it can result in less effective treatment, as the client may find an element of their beliefs to be at odds with a prescribed treatment (pharmaceutical or behavioural), or the beliefs themselves may be the source of, or a contributing factor to their illness (Rosner, 2001). While there is a reluctance to address spirituality by formal mental health care professionals for reasons ranging from time constraints, lack of specialized knowledge, to fear of offending, there is little evidence of consistent collaboration between clergy and formal mental health care professionals (Leavey, 2008; Rosner, 2001). Observations from previous studies have attributed this to the clergy's perceived lack of training in the area of mental health (recognizing, treating, knowledge of referral resources), lack of perceived common values with formal mental health professionals, and negative attitudes regarding religion held by many health professionals (Wang et al., 2003). While some research exists on the intersection of the formal

mental health care system and the informal mental health care that clergy provide, more work remains to be done on the subject, particularly in terms of qualitative Canadian research.

It could be of great benefit to encourage professional collaboration between formal mental health care professionals and clergy (Kramer et al., 2007;Mathews, 2011; Young, Griffith, Williams, 2003). For example, approximately 15% of the population is affected by depressive disorders – however less than half of those affected seek any kind of treatment. Barriers to treatment include perceived stigma of approaching a formal mental health care professional, availability of formal mental health professionals, cost of treatment, and perceived lack of understanding with regards to religious and cultural beliefs (Kessler 2003; Center for Disease Control, 1999).

Between 20% and 60% of the general population and 80% of a sample of individuals with a mental illness reported using religion is a means of coping (Gearing, Alonzo, Smolak, McHugh, Harmon & Baldwain, 2010). A relationship between schizophrenia and religion is acknowledged, but it is not well understood. One study found a mixed relationship between religion and schizophrenia, with data indicating that religion may be both a protective and a risk factor for schizophrenia. The same study also found a mixed relationship between religiosity and treatment adherence. Once better understood, this relationship may be useful in promoting treatment adherence (Gearing et al., 2010). Other data suggests that religion may be useful means of coping with mental illnesses such as schizophrenia, major depression, and other mental illnesses (Tepper, Rogers, Coleman & Maloney, 2001). By developing professional relationships with clergy, formal mental health care professionals could not only take advantage of their expertise in spirituality, but also begin to overcome many of the barriers that their service users experience trying to access formal mental health care professionals. With the assistance and collaboration of formal mental health care professionals, more effective care could be provided

to a greater number of individuals affected by mental illness (Edwards, Lim, McMinn & Dominguez, 1999).

There is a distinct lack of Canadian literature examining the services that clergy provide to individuals suffering from mental illness. Further, while current literature indicates an increasing interest in spirituality as a positive mediator in prevention of and recovery from mental illness, there is still a lack of current, qualitative research investigating the experiences and perspectives of clergy who are functioning as informal mental health care providers.

Research Question and Objectives

The aim of this study is to explore the experiences and perspectives of United Church ministers in their role as informal mental health care providers.

A semi-structured interview guide composed of open-ended questions designed in conjunction with a professional in the field was developed to explore the role ministers of the United Church as informal mental health care providers. Questions were developed (see Appendix B) as general and open-ended so as to stimulate discussion in a non-biased way. During the conversation, further ad-hoc probe questions were posed by the interviewer to pursue relevant topics, namely: the quality and nature of the relationship between ministers of the United Church and formal mental health care professionals, training and experience related to mental health, confidence and boundaries in dealing with mental health, and relevant challenges and facilitators.

Theoretical Framework

Considering that there has been little research regarding the role of ministers as informal mental health care providers, a qualitative approach was selected – the main advantage being that qualitative methods can be informed by the resultant data, whereas quantitative methods are far

less flexible in this regard (Sandelowski, 2000). The principal goal of qualitative research is elegantly outlined by Pope and Mays: " . . . To understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences, and views of all the participants" (Pope & Mays, 1995, p. 43).

This study was approached from the social constructivist tradition. The central tenet of the constructivist tradition, according to Foucault's description, is that it is impossible for the observer to extricate himself or herself from the world they endeavour to describe without bias (Guba & Lincoln, 2000). This research methodology did not attempt to reveal a particular truth, but rather to assemble the accounts of many ministers in a way that most accurately represents their reality.

With the ultimate goal of this study being to explore the experiences and perspectives of United Church ministers in their role as informal mental health care providers, fundamental qualitative description as described by Sandelowski (2000) was selected as the ideal methodology. Sandelowski (2000) describes fundamental qualitative description as being well suited to studies that are designed to investigate situations that may be of particular interest to practitioners and policy makers. Fundamental qualitative description also has several distinguishing features that make better suited to the purposes of this study than other qualitative methodologies. One of the chief features is that although there is some interpretation of the data, unlike methodologies such a grounded theory, phenomenology, and ethnography, the interpretation of fundamental qualitative description uses everyday language. Secondly, since there is less departure from the data (particularly when compared to other methodologies that generate predictive or explanatory theories), there is a greater likelihood that a consensus will be easily achieved among both researchers and participants – lending a great deal of validity to this methodology (Sandelowski, 2000). A final important feature of fundamental qualitative

description is that it seeks to provide observations of an event as if it is not being observed at all – perhaps resulting in the most accurate account of a phenomenon's natural state (Sandelowski, 2000). With the exploratory nature and the potential for the practical applications of the results in mind, fundamental qualitative description is ideally suited to examine the experiences and perspectives of ministers in the United Church as informal mental health care providers.

One of the most common criticisms of qualitative research is that it more prone to bias when compared to quantitative research (Mays & Pope, 1995). Of course, some bias inevitable; as researchers, bias is present from the moment data collection begins as we select what is or is not noteworthy (Mays & Pope, 1995). However, this potential bias can be kept to a minimum by using rigorous methods of observation and analysis as described by Mays & Pope (1995).

Fundamental qualitative description is described as "less sexy" than other methods for conducting qualitative research studies (ethnography, phenomenology, grounded theory, or narrative analysis for example), but in recent years it has been given more credibility and respect as a valid tool for producing data (Sandelowski, 2000; Sandelowski, 2010). Qualitative description does not claim any predictive power by constructing theories that may be generally applied; the purpose of qualitative description is simply to describe the matter at hand in a factual and relatively un-biased fashion (Sandelowski, 2000). The goal of this qualitative descriptive study is to describe the content of the interviews with the clergy of the United Church, and to distill the recurring themes so that they may be examined in detail. As with all scientific methodologies, there are limitations to qualitative description. While fundamental qualitative description produces perhaps the most incorruptible account of the facts of a given phenomenon when compared to other qualitative methodologies, it lacks the predictive and explanatory power of other more epistemologically complex techniques. Conversely, the advantage of a fundamental qualitative descriptive study is that it provides a relatively unbiased account of

events, which may be used as a springboard for other studies, or may simply serve to stimulate constructive conversation within the discipline (Sandelowski, 2000).

Chapter 2: Methodology

The United Church of Canada

The United Church of Canada is the largest Protestant denomination in Canada, with nearly 3 million Canadians identifying themselves as being affiliated with the United Church (Statistics Canada, 2001). The following facts were retrieved from the United Church of Canada's official website (retrieved 2013). In 1925, the Methodist Church, the Congregational Union of Canada, and over two-thirds of the Presbyterian Church of Canada came together to form the United Church of Canada with the intention of improving services to more remote areas of Canada and improving the quality of overseas missions. The United Church is well known for its progressive social policies advocating gender equality and equality for same-sex couples. The United Church supports the ordination of men and women (regardless of sexual orientation), same-sex marriage, access to contraception, sex education, and abortion services (United Church of Canada, 2010). The United Church was selected as the focus of this study because of its prominence in and relevance to contemporary Canadian culture, in addition to the author's own personal affiliation with the denomination.

Participants

Twelve ordained ministers from the United Church were recruited to participate in the study. Recruitment was facilitated by the author's personal relationship to the Montreal United Church community. A solicitation of participation letter was sent to churches in the Montreal area to recruit participants. However, the majority of the participants in the study entered through the "snowball sampling" method (Morgan, 2008). At the end of each interview, ministers were asked if they would refer interested colleagues to participate in the study, and each minister offered two to five suggestions for potential participants. To have been considered for inclusion

in the study, ministers were required to meet the following criteria: must be working as a minister for the United Church of Canada, experienced in urban ministry, and able to converse easily in English. During the recruitment process, the researcher made conscious efforts to include a representative number of women in the sample, since the ordination of women is one of the principle activities that distinguishes the United Church from some other Christian traditions. Ultimately, 16 invitations of participation were extended, 13 accepted to participate, and 12 ministers (3 women and 9 men) met the criteria of the study to participate.

Methods of Data Generation

The principle method of data generation was through semi-structured interviews with participants. The topic guide provided in Appendix B was used as a starting point for discussion, which was otherwise allowed to progress naturally. During the discussion, the interviewer offered further probe questions to clarify or pursue meaningful information. Interviews were audio recorded. Of the 12 interviews conducted, 10 were transcribed and analyzed by hand to extract relevant themes. After 10 interviews were transcribed the author found that saturation had been reached. Thus, the author simply listened to the remaining two interviews to ensure no new themes emerged and directly recorded any corroborating quotations. Interviews were conducted at a place of the minister's choosing – either their church or office, the minister's home, or a public setting such as a cafe. Other methods of data collection involved taking pictures of notice boards in the community, collecting available pamphlets, and interacting with the church community in general by attending services, recreational activities with the youth group, and volunteering for general church events.

Data Analysis

Audio-recorded interviews were transcribed verbatim, and subsequently coded by hand for analysis of themes. To ensure quality of the analysis, an expert in qualitative research was consulted in the transcription and analysis phases of the research. If there was any disagreement regarding the transcription, importance, or coding of a particular theme, a consensus was reached through discussion. When the conclusions of the study were completed, two key informants were selected to validate the results through a discussion of the most important themes with the researcher (Mays & Pope, 1995).

Ethical Considerations:

The study was conducted according to ethical principles stated in the Declaration of Helsinki (2008). Ethical approval from the McGill Faculty of Medicine Research Ethics Office was obtained before commencement of the study. Before commencing data collection, participants were fully informed as to their rights within the study, as well as their right to withdraw from the study at any time. Both the minister and the researcher signed a detailed written consent form, and a copy was provided to the minister. Consent forms took into consideration the well-being and free will of the ministers, with special emphasis on the anonymous nature of their participation. Individual participants have been rendered anonymous through the use of pseudonyms for names, places, or other information that could reveal the identity of the speaker. No compensation was offered for participation in this study.

This study also has its own intrinsic ethical value. As a precursor to examining the issue of collaboration between formal mental health care professionals and clergy, the study must first determine what support ministers are willing to provide, and to what degree they are qualified and feel capable to provide this support (both in terms of formal qualifications, availability, and

their own personal sense of comfort and ease). For example, although clergy may be approached for spiritual guidance, due to the inevitable intertwining of mental illness and spirituality, clergy are often obligated to act as an informal mental health worker. Thus, it will be important to determine how the clergy in this study delineate their role when offering spiritual guidance from that of a formal mental health care professional. Previous literature has reported that clergy are reluctant to make referrals to members of the medical community (Matthews, 2011).

Chapter 3: Results

In reporting the results, all names of people and places have been changed to pseudonyms. The same pseudonym has been maintained for the same person or place throughout this report. In presenting the results, there are three sections: how ministers serve people with mental illness, ministers' experiences of working alongside formal mental health care professionals, and finally facilitators, barriers, and future directions. Themes within each of these sections are explored.

3.1 Ministers Supporting People with Mental Illness

In general, ministers described their role as quite broad and undefined with regards to mental health, though they reported that congregants frequently sought their help with regards to suspected mental illness. Ministers often described themselves as a bridge between the individual and formal mental health care professionals. While not traditionally perceived as formal mental health care professionals, ministers described a variety of ways in which they provided support to people suffering from illness. Interestingly, they also described certain advantages that they had over many formal mental health care professionals. A nearly universal feature of the interviews was that ministers quickly described the limitations of their qualifications and abilities, and how they communicated these limitations to their congregants. Ministers regularly referred people they suspected had a mental illness to formal mental health care professionals.

3.1.1 Ministers' Definition of their Role in Mental Health and Wellness

Although poorly defined, the role that ministers played in supporting the mental health and wellness of their community was important, both through detection of suspected mental illness and also through ongoing support for those diagnosed and living with mental illness.

Participant 1 provided a definition of ministers' role in mental health that underlined the

uniqueness of the service ministers provide:

> . . . My job is not to cure people . . . of whatever ails them. It is to listen to them and let them talk about anything, and to let them talk about stuff that a lot of other professionals aren't either open to, or willing to, or able to talk about.

Ministers often described filling in the gaps where the formal mental health care system failed; ministers typically received requests for support when people could not afford private treatment or when they were having difficulty engaging the public system. Participant 2 defined the role quite simply: "The role of the pastor is to be a bit of a generalist."

Ministers often reported providing short-term interim support while people were waiting to access formal mental health professionals: " . . . We can be a weigh station to help" (Participant 3). They can also help in navigating the complex, and often disorganized system of public services offered to people with mental illness. Some ministers described themselves as being unable to personally offer treatment for a suspected mental illness, but they would help find resources in the community that could offer specialized help.

Another minister spoke of the importance of relieving people of the stress of a guilty conscience:

> Part of my job is to give them permission at some level to be like that: ' . . . Is this wrong? Should I think like this? ' So a lot of it's just releasing people from their guilt, and that's something I can do. . . . So we can release a lot of tension and pain and guilt that way (Participant 4).

Ministers often described simply looking at the overall well-being of an individual, and making suggestions that might result in positive changes:

> I act as a sort of informal doctor, in a way. I don't diagnose anything. But I would look at what's the person doing for their well-being? Are there obvious gaps there? Do they take

exercise? Do they eat well? How are they sleeping? How much do they drink – alcohol, water?" (Participant 5).

Although ministers reported regularly dealing with mental illness in their role as clergy, they did not feel that their role was clearly defined or well understood: " . . . We may be on the front line, and we may be quite accessible, but our role is really undefined" (Participant 6). Although the ministers felt their role with regard to mental illness was unclear to the general public, formal mental health care professionals, and even among their colleagues, individual ministers were quick to define the limitations of services they could offer to people with suspected mental illness.

3.1.2 Defining Roles: Limitations

Virtually every minister who participated in the study would spontaneously declare, in a very similar tone and with very similar language, using key words and phrases such as: (we are not) "psychologists", "psychiatrists", or "doctors". Participant 7 put it most succinctly: "This [the church] is not a psychiatric institution, and we are not psychiatrists". Ministers were quick to clearly define their limitations in terms of the of type support they could offer to people suffering from suspected mental illness. Ministers tended to discuss individuals with suspected mental illness in terms of symptoms, rather than in terms of diagnosis – with many further clarifying that they did not have the ethical or professional ability to offer a diagnosis.

Many ministers had established barriers to prevent their role as clergy being confused with that of a formal mental health care professional. For example, Participant 7 had practiced previously as a psychotherapist, but deliberately let their insurance and license lapse to prevent their role as clergy becoming confused with the role of a formal mental health care professional:

> . . . Here I was their pastor, and not their therapist. And so to maintain the integrity, my own personal integrity, I could then clearly say, "I am unable to engage you as a psychotherapist, given my license and insurance."

In addition to Participant 7 having practiced as a psychotherapist, Participant 3 and Participant 8 had training in neurolinguistic programming. Ministers were eager to distinguish between their role as clergy and the role of a formal mental health care professional to ensure that they were not giving unhelpful support or creating an inappropriate relationship: " . . . There's something in us that wants to help but we have to be careful that we don't create co-dependency" (Participant 2).

Defining their role when helping people with mental illness was very important to ministers; the emphasis that ministers clearly placed on professional boundaries was borne out of a desire to protect their personal and professional integrity, in addition to ensuring that individuals with mental illness received the benefits of care from a formal mental health care professional. Although ministers were quick to emphasize their limitations in terms of offering mental health support, they also outlined many ways in which they could provide support to people suffering from mental illness.

3.1.3 Support Ministers Provide

Ministers described providing a variety of largely informal services to people with mental illness. Ministers reported offering private meetings to provide emotional support and some guidance. They also reported helping people to engage formal mental health care professionals.

Ministers reported frequently offering spiritual support to people with mental illness. Participant 9 noted that in cases of long-term illness, the need for a spiritual aspect to care may become more pronounced:

> The questions get more intense after a period of time – I would say 15-20 years into a treatment. People get, often, quite despairing and look for spiritual support at that point to kind of find a *reason* [italics added] and a *what* [italics added] to keep going.

One way of offering spiritual support for a mental illness was to offer biblical passages and stories. Several ministers reported referring to Psalms 22, 23, 46, 139 – psalms that speak primarily of God's love and presence. Ministers often received requests from friends, family, or the individual to simply pray with them or for them. Many churches offered a section during their services where parishioners could request that the congregation pray for themselves, a loved one, or simply a member of the community in need of support. Despite their vocation, ministers tended to rely less directly on religious resources (such as the Bible, prayer, worship services) when helping people cope with mental illness. Participant 2 said, "A person needs more than my prayers and I think as important, as fundamentally important as they are, they need treatment, and I need to be prepared to offer that." The general consensus among ministers about using religious resources when helping someone through a difficult period was: "Yeah, you use it – but advisedly" (Participant 6).

Most ministers felt comfortable offering short-term support (usually while they assisted the person in connecting with other resources), but would establish safe-guards so that they were not perceived as formal mental health care professionals:

> If I think it's going to be kind of a short-term or a support system I will . . . So the whole idea is . . . I will work at a certain level with folk and then I will say, "I think you need to go see someone else and work it through" (Participant 3).

Ministers mentioned several challenges that patients of formal mental health care professionals faced when navigating the complex network of medical support. They spoke of difficulties in terms of a lack of resources for people with mental illness, a lack of knowledge of

where to find help, and congregants complaining of negative or disappointing treatment experiences from formal mental health professionals. In those situations, ministers offered advice and support:

> I sort of coach people to have another go . . . often that's enough for them to sort of get into the medical support that they need. And it also, it empowers them to have a higher expectation of their doctors (Participant 5).

Some ministers even mentioned offering to accompany people to medical appointments if they were reluctant to go by themselves.

In offering a safe place for people to express their thoughts, ministers spoke of the comfort, hope, and inspiration that their congregants reported feeling as a result. One minister described how an individual thanked them for their support during their struggles with mental illness: ". . . You've just been the source of strength and support, and you know, I couldn't have done it without you and your inspiration . . ." (Participant 10).

Ministers can provide valuable support to people suffering from mental illness: emotional support, referral services, general information, and welcoming them as part of the community. When confronted with someone with suspected a mental illness, ministers habitually referred them outside of the church to formal mental health care professionals.

3.1.4 Referral Practices of Ministers

Often, the first question ministers reported asking individuals with suspected mental illness was: "Have you talked with your doctor?" (Participant 5). Ministers frequently encouraged individuals with suspected symptoms of mental illness to contact formal mental health care professionals. In some cases, ministers even offered to make first contact with a formal mental health care provider if the individual was unable to do so independently. Some

ministers also reported arranging to accompany people to their medical appointments. Ministers frequently referred individuals to various resources publicly funded resources including CLSCs, mental health clinics, and day centers. Ministers also reported trying to engage the individual directly with physicians, psychologists, social workers, and nurses. Ministers tended to perceive themselves as a sort of informal triage service. They often described working with people with mental illness on a short-term basis to fill in the gaps where the publicly funded health system failed. They typically did not offer long-term treatment, or try to treat specific illnesses. Participant 1 said: "I'm not gonna treat them, I'm going to intervene and get them to somebody who can".

During the interviews, ministers expressed no hesitation in referring individuals with suspected mental illness to formal mental health care professionals. Some ministers even deliberately developed personal relationships with formal mental health professionals within their communities with the intention of creating a support network for people with mental illness. However, at the time of the interviews, most of these relationships had not resulted in a professional connection, mostly because of patient/congregant confidentiality issues.

Ministers were all well informed about where they might refer someone who had a mental illness. The majority of ministers named two to four different resources they might offer a person with suspected mental illness. Ministers commented on the importance of knowing what resources were available publicly and privately, and knowing when to refer people: " . . . It's also a matter of saying, you know, we can't be all things to all people and recognizing again that there are other resources out there" (Participant 11).

Ministers who participated in this study were willing to refer people with suspected mental illness on to formal mental health care professionals. Further, although their role in the mental health of their community was poorly defined, most ministers had firm definitions of

what services they could not provide. Further to working one on one with people suffering from mental illness, ministers also reported working to combat the negative stigma of mental illness.

3.1.5 *How Ministers Address the Stigma of Mental Illness*

Visiting a formal mental health care professional can be taboo or intimidating for fear of the discovery or labeling of an unrecognized problem. Conversely, as Participant 6 observed, visiting and speaking to a minister is not accompanied by the same set of challenges as is speaking to a formal mental health care professional:

> . . . It doesn't up the ante so much. If you come in, say, "Can I have a cup of coffee with you, I want to talk to you about this thing that's been running through my head." Well there's not necessarily a pathology put to it. You're not asking me for a diagnosis, you're not looking for a prescription.

In this way, ministers felt they had an advantage over formal mental health care professionals. Once the conversation about mental health was initiated, they could encourage the individual to take further steps to overcome their mental illness.

Ministers often spoke of the simple lack of awareness and understanding regarding mental illness. Despite the good intentions of many communities, Participant 7 acknowledged: "Although a community often wants to provide help, sometimes they simply do not know what to do." The support of a community is very important to individuals experiencing mental illness. Additionally, the community benefits from offering support. Ministers generally promoted the understanding and inclusion of people with mental illness to the benefit of all members through their ministry.

Beyond promoting a welcoming and inclusive environment in their community, one interesting method of combating the taboo of mental illness was ministers being open about their

own struggles with mental illness. Participant 1 spoke of using their own personal experience with mental illness to create awareness by incorporating that story into their ministry.

The taboo of mental illness remains a significant challenge and barrier to many sufferers. Though the generally acknowledged that work still remains to be done, ministers reported providing some relief to this taboo through their personal interactions and the way in which they guide their communities. Further to the taboo of mental illness, there is the difficulty of obtaining treatment for a mental illness through the publicly funded system. By providing support for people with mental illness, ministers can provide some relief while people are waiting to be seen by a formal mental health care provider, and perhaps even reduce the burden on an overextended system.

3.2 ***Working Alongside Formal Mental Health Care Professionals***

Although few formal collaborative agreements exist between formal mental health care professionals and ministers, many of these professionals are (perhaps unknowingly) working alongside clergy. The ministers in this study rarely described collaborating directly with formal mental health care professionals in urban settings. Conversely, the same ministers often provided accounts of placements they had done in rural settings and described fairly extensive collaboration with formal mental health care professionals. Further themes that arose that impacted how ministers were able to work alongside formal mental health care professionals were the perceived attitudes of formal mental health care professionals toward religion, ministers' attitudes toward medication, and exorcism as a form of therapeutic treatment.

3.2.1 *Collaboration Between Ministers and Formal Mental Health Care Professionals*

Ministers generally reported little direct collaboration with formal mental health care

professionals in an urban context. Collaborations usually occurred through the person in crisis, if at all. Ministers frequently referred problems they perceived as being related to mental health or symptoms of mental illness to outside community resources (CLSCs, mental health clinics, and private therapists). One challenge to interdisciplinary collaboration was the issue of confidentiality; a minister could not approach a formal mental health care professional directly to discuss a specific individual, and vice versa. Some ministers suggested that this could be easily overcome by receiving direct permission from the patient for the minister and the formal mental health care professional to share information.

While working as a chaplain in a hospital, Participant 9 observed:

> Once in a while, a nurse or a doctor will recognize a need and ask for a pastoral visit. It's not nearly as frequent as you might think. A lot of the nurses are more ready to do this than the doctors. The doctors tend to ask us when they have a really puzzling case.

Participant 9 also reported being contacted by psychiatrists for help defining the normal limits of religious behaviour:

> . . . Someone will claim to have visions or particular interpretations or messages from God and the psychiatrist wants to know, sometimes, whether that falls within what a religious person would consider normal limits . . . And if it's something terrible, then we mostly think, "Okay, that sounds more like illness than faith." And if it's good stuff, you think, "Oh, that's affirming, we're glad for that." Both could be illness, and both could be faith.

With the cultural diversity found in contemporary Canadian society, it is not uncommon for a patient and their formal mental health care professional to be of different religious backgrounds, making it difficult to distinguish between what might be considered a symptom of illness, and what may be part of their cultural identity, or in some cases even a helpful coping strategy. Ministers who participated in the interviews were well placed within the Christian

community to provide relevant insight.

For the most part, ministers had little to do with formal mental health care professionals if they worked in a church. Participant 6 observed:

> . . . I have no direct access. So if I call a CLSC and say, 'I'm real concerned about a member of my congregation,' I'm basically told that it's none of my business, that they cannot speak about, they cannot act on it, they cannot do anything . . . If I had a special concern about that, maybe 1 in 10 times I can really have a discussion.

Many ministers cite reasons of client confidentiality for the lack of collaboration. However, ministers indicated that this could be easily overcome by obtaining permission from the patient.

Participant 7 described an extremely positive experience collaborating with an urban psychiatrist. At the express request of the psychiatrist, the minister performed an exorcism. Participant 7 said of the experience: "I thought this psychiatrist was brilliant, because he could have just knocked her out with every conceivable drug and you know, would have taken her down a whole road of Lord knows *what* [italics added]." The minister credited their previously established personal friendship, and the trust that arose from that relationship for enabling them to work together with confidence to provide the patient with the best possible support.

Participant 3 described a centre the church created where ministers offer free short-term support services to individuals who cannot afford private therapy. Due to demand, the centre has now grown to include both ministers and volunteer psychologists providing counseling, free of charge on a short-term basis for people in financial need. Notably, Participant 3 was the sole minister who reported receiving referrals from CLSCs and palliative care centers on a regular basis – likely because of their involvement with the aforementioned center. Although this minister did receive referrals from CLSCs and palliative care units, the minister went on to specify that they had never received a referral directly from a physician.

Several ministers spoke of times they spent working in remote communities where resources were extremely limited. The ministers described the nurses and general practitioners as so overwhelmed with demand that they found it useful to work closely with the resident minister, simply because there were no other alternative resources such as community centers, social workers, psychiatrists, or psychologists. Describing their time working in such a setting, Participant 2 said: " . . . There were two doctors, four nurses, and the minister, and we worked together a much as possible to try and handle some of the stuff . . .". When describing these types of collaborations, ministers had largely positive things to say about their experience. They felt the formal mental health care professionals appreciated their work and valued their input, and they also reported that the interests of the patients were well-served by this collaboration.

However, in the typical urban setting (other than hospital chaplains) most ministers reported having little direct contact with formal mental health care professionals. Participant 6, who had described making several attempts to reach out to formal mental health care professionals, said:

> But I do think that ministers are very generally not seen as part of the team. They might be asked to provide spiritual care. We're definitely asked to go in when nobody else can do anything else . . . so that frees them up in a way.

Interestingly, Participant 10 commented: " . . . The best times are when we see it's complementary," in reference to observing the best results when their support and that of a formal mental health care professionals were applied simultaneously. However, the major barrier to this kind of interdisciplinary collaboration is what ministers perceived as a negative attitude towards religion by formal mental health care professionals.

3.2.2 *Perceived Attitudes of Formal Mental Health Care Professionals toward Religion*

Ministers tended to perceive that traditional mental health care providers had a generally negative attitude towards religion. Participant 1 said:

> But I think a lot of doctors don't understand how we, as spiritual professionals, spiritual leaders, can have something to offer because religion has a bad name; *especially* [italics added] in a secular society.

Participant 7 added:

> You know, I think this may be a really broad statement, that . . . there's a certain negativity on the part of some of the medical milieu or psychiatric institutions in terms of church. You know, stereotypes of what we are and what we are not . . . My own hypothesis on this is for many folks who have mental health issues, that's so often related to religious imagery. Especially psychoses, you know: voices and God, and all this kind of stuff. And somehow, sometime I think again we're perceived by some folks as the source of that problem, rather than someone who can help address the problem.

Despite these perceived negative attitudes, ministers consistently reported encouraging people to engage formal mental health care professionals when experiencing symptoms of a suspected mental illness.

Issues regarding faith and spirituality can often be intertwined with mental illness, particularly depression. Several ministers reported anecdotal evidence that formal mental health care professionals are not necessarily equipped to address issues surrounding spirituality and faith. Speaking of their personal experience of working with formal mental health care professionals for treatment of a mental illness, Participant 1 said:

> . . . My own experience plus that of other people reported to me is that most medical professionals are not comfortable with talking about spiritual issues . . .When I would

> name stuff around my own spiritual and religious stuff, most of them couldn't handle it. And from time to time I was told that this is not a place to be discussing religious stuff.

Despite these accounts, there were few reports of medical practitioners referring individuals to ministers when they encountered a spiritual issue they were not able to address. Participant 1 said:

> And I don't think that physicians are generally trained – I don't know this for sure – but I don't think physicians are generally trained to refer anywhere outside of the medical sphere. And so the only ones who would, would be ones who are already people of faith. But if you have a Jewish doctor who has a Christian patient, he or she is not necessarily gonna know the resources to refer a Christian person to.

Beyond a simple lack of knowledge, a common sentiment among ministers was: " . . . For some of our professionals, any religious talk is just nutty" (Participant 6).

On a personal note, Participant 6 expressed that their family physician likely did not understand their role in the United Church, since they were of another Christian denomination. Participant 2 reported that they would specifically mention to colleagues that they should avoid presenting themselves as ministers when going for medical treatment:

> I always say to people that when you go into to see a doctor . . . you don't need to tell them you're Reverend John Smith. Go in as John Smith because things do change slightly . . . You either get the ones who, "Yes, of course, Reverend," you're ushered right in and Mrs. Gilliguty can wait, you know, she's not bleeding that bad . . . or you get the opposite in the province of Quebec, you get the anti-clericalism where, you know, "I'm pissed off at the priest or the minister because, you know, he didn't do a good job at my sister's wedding . . . and I hate clergy."

During the interviews, there was a general consensus that formal mental health care professionals

could often be influenced by their own personal biases with regard to religion. Further, ministers often reported formal mental health care professionals demonstrating a lack of knowledge of religion.

In contrast to the reports from ministers about their time spent in urban church settings, very different reports emerged from the same ministers who had spent time as hospital chaplains in an urban setting. During their time as a hospital chaplain, ministers interacted with formal mental health care professionals and actively contributed to patient treatment. In this setting, the ministers felt their contributions were welcomed and encouraged. Speaking to Participant 9, they reported that in recent years the role of the church in hospitals had diminished significantly. Participant 9 reported that several years ago, there had been several full-time staff in the hospital chaplain's office, and at present there was only one full-time staff member. Due to cuts in services, the possibility for interdisciplinary collaboration within the hospital was significantly diminished.

Collaboration between ministers and formal mental health care professionals also has the potential to encourage medication compliance – an important issue in the treatment of mental illness. Many medications have side effects that patients find difficult to deal with, thus fueling non-compliance. Particularly in the case of an outpatient, physicians have little control over if a patient complies with medication. Based on the results of the interviews, an unexpected source of encouragement for medication compliance may be ministers.

3.2.3 *Ministers' Attitude towards Medication*

Ministers participating in the interviews generally all expressed positive attitudes towards medication compliance and treatment adherence. Ministers often described encouraging people to adhere to the pharmacological treatment regimen prescribed by their physician as a first step

in their recovery. Many ministers had stories of watching people recover after starting a medication regimen. Further, ministers often spoke of encouraging people to maintain the prescription regimen that their physician had recommended. If someone reported dissatisfaction with some aspect of their treatment, ministers said they would encourage people to speak to their doctors about changing or adjusting their medication, but never advocated stopping medication. Participant 9 said, "So I don't preach medication ever, it doesn't matter to me as a chaplain whether people take their meds or not . . . I do accompany people through their own questioning of that role, of their situation." No ministers reported discouraging people from taking their medication, or otherwise encouraged disregarding formal mental health care professionals' recommendations. Overall, ministers in this study were very engaging and open minded with regards to psychiatry, but in their opinion this attitude is not reciprocated by formal mental health care professionals.

Ministers did acknowledge that physicians were liable to prescribe medications inappropriately. One minister described how they observed medication being used during the time they spent doing pastoral care in a psychiatric hospital: "And so I saw a lot there, saw how medications were used, and I think abused in some cases, understandably." However, these stories were always countered with stories of other individuals doing poorly when not taking their prescribed medication.

Interestingly, ministers were in a position to observe people both before medication, during treatment with medication, and also during periods of medication non-adherence. Participant 10 remarked with reference to one of their congregants, " . . . It's so sad, she's either so drugged she's a zombie, or she's not on drugs, she's so unwell." Although many pharmaceuticals have side effects that can be difficult for the individual to tolerate or manage, when mental illness is left unchecked without pharmaceutical intervention the outcome can often

be worse. Ministers recognized not only the advantages of medication and the associated difficulties in maintaining medication compliance, but also the difficulty associated with making the decision to prescribe and take medication. Ministers may be unexpected sources of support for helping patients adhere to their medication regimens.

A rather unexpected theme that arose in this study was that of exorcism. In some cases, formal mental health care methods of therapeutic treatment may not be sufficient. Three ministers reported being asked to perform exorcisms, and two agreed to participate in the intervention. Both ministers who participated in the exorcism intervention reported positive results for the patient.

3.2.4 *Exorcism and the United Church*

Exorcism is an activity not typically associated with modern mainstream Christianity, and particularly not with the United Church. Despite this, three ministers described an instance of receiving a serious request for an exorcism. Two ministers agreed that this might be helpful for the individual; however both ministers described receiving these requests with a certain measure of reservation. Participant 6 said:

> . . . We try not to whip up the devil too much, and . . . there's no holy water, no heads turning around. But if people feel that they're beset by the devil, I think I offer prayer, you know, suggesting God is with them.

Although the United Church does not formally recognize exorcism as kind of treatment, both ministers reported working with the patients' desires and expectations, both ministers were working in conjunction with a formal mental health care professional, and both reported improvement in the patient's condition after treatment.

A woman, Mary, approached Participant 5 to perform a baptism for her child. Through discussion with Mary, the minister discovered that amidst a myriad of difficult circumstances she was also likely experiencing symptoms of mental illness:

> I visited her and talked to her about what she thought could work . . . So she wanted to go for an exorcism and I agreed that this was at least something she could do, and uh, not something the United Church does or can do; it has to be her own church.

The minister was invited to share in case conferences with Mary's treating formal mental health care professionals to voice ethical and cultural considerations on Mary's behalf. Ultimately, Mary was approved for transfer from Montreal to another urban centre to have an exorcism ceremony performed by her own church. In Participant 5's words: " . . . it worked ". At Participant 5's last contact with Mary she was coping well. Participant 5 described being very impressed with how her treating formal mental health care professionals handled Mary's case, in the sense that they were open to approving the use of an unconventional treatment. Participant 5 emphasized that ultimately, it was impossible to know with certainty whether it was the drugs Mary was taking at the time of intervention or the religious ceremony (exorcism) that made the greatest contribution to her recovery.

Participant 7 reported receiving a request for an exorcism, however not from a patient, but rather from the treating psychiatrist:

> When he asked me if I would perform the exorcisms, I kind of, you know, chortled, and he chortled as well. But he was very serious in terms of what he was looking for, and would I come and see this patient?

Angela was also a young woman who identified as Christian and had ties to Caribbean culture. The patient was in major crisis, and Participant 7 described her as being similar in behaviour to the portrayal of possession in the film *The Exorcist*: "a lot of hissing, and spitting, and cursing,

and writhing and this kind of stuff . . .” Participant 7 reported ascertaining that this woman was experiencing a spiritual crisis in addition to some possible psychological concerns:

> . . . In her mind it was uh possession by demons and it turned out that in her childhood, in the culture she came from, that her, that apparently her father had sold, you know, the souls of his children to the devil for whatever. And this seemed to be now a major preoccupation with this . . . patient.

After ascertaining that the woman was experiencing a spiritual crisis, Participant 7 began their intervention:

> . . . So I tried intervening in terms of uh on the spiritual side . . . trying to being a positive energy of God, in that Christian context that was hers. Um, that I portrayed as being stronger and greater than that force of what she would have called, or that would been evil, in that context. . . . so after many hours of sort of shorter interventions, managed to get her *reasonably* [italics added] quiet, although it would happen – she would sort of flare up. I managed to get a cross in her hand, which she then continue to hold on to, which I figured was a pretty good sign . . .

Within a few days of this intervention, the patient had returned to what Participant 7 described as “ . . . A very coherent state.”

Evidence of exorcism being helpful in cases of mental illness was limited; only 2 of 12 ministers interviewed described its use, and both described only a single incident. However, it should be noted that the topic of exorcism was never broached directly by the interviewer, but arose spontaneously during the interviews. In the two cases reported, both the formal mental health care professionals involved and the ministers involved worked together and reported improvement or functional recovery for the patient.

3.3 Facilitators and Remaining Challenges for Ministers when Dealing with Mental Illness

Aside from the two main topics of how ministers serve people with mental illness and how they work alongside formal mental health care professionals, several other important and distinct themes emerged. These themes are best described as factors that facilitate the role of ministers providing support for people with mental illness and the remaining challenges. Ministers reported certain advantages they felt they had over formal mental health care professionals when providing support to people with mental illness. The advantages they named were: an inherent trust in the profession of ministry itself and the support of the church community. Ministers also named significant challenges: the paucity of resources for people with mental illness unable to finance private treatment, limitations of the congregations' financial resources and limitations of the ministers' time. Finally, the most significant challenge was ministers' perception of their religious colleagues – both within the United Church and other branches of Christianity.

3.3.1 *Advantages Ministers Have Over Formal Mental Health Care Professionals*

Although not normally perceived as formal mental health care professionals, ministers are in an important position of trust, authority, and leadership in their communities and often have to provide support to people with mental illness. Factors such as accessibility, financial barriers, confidentiality, and stigma can be barriers for people trying to access treatment from formal mental health care professionals. In a certain sense, ministers may hold certain advantages over formal mental health care professionals because the barriers associated with them may be greatly diminished or non-existent when seeking services from a minister.

One of the most frequently reported facilitators for ministers dealing with mental illness was having regular, casual contact with parishioners. Unlike a physician who sees people by

appointment, or as a walk-in after waiting in a clinic for several hours to be seen, ministers can be found at the church every Sunday and even throughout the week with or without an appointment. Outside of the regular Sunday service, there is often a time after the service where parishioners can chat with one another or with the minister. In reference to this period after the service, Participant 7 said: "I mean it's really clear on a Sunday morning sometimes who's there with, you know, mental illness, and that can be because they're acting out." To further simplify contact, some ministers even make their personal home phone numbers available to congregants.

Ministers mentioned how they felt perceived as established and trusted members of the community, which they felt contributed to their approachability. Participant 3 said: "They know who I am, what I am, and there's a real trust." Further, ministers reported that people tended to have implicit trust in clergy that they may not have in formal mental health care professionals. Participant 9 said: "Most people, in spite of all the disasters that have happened in clergy around the world, and all the horrible stories we've heard about exploitation of others, most people still have a general trust of clergy . . ." Although ministers in the United Church are not bound to confidentiality in the same way clergy are in some other denominations (for example, they are obligated by the United Church to report to the appropriate authority if someone poses a serious threat to themselves or another), Participant 1 commented that confidentiality was still something people associated with United Church ministers: " . . . That concept of ministry that people can come to and say anything to me and know that that's confidential and won't be shared uh in any way that you know, breaks their confidentiality." While the perception of confidentiality of United Church ministers remains, they are not bound to retaining parishioner/minister confidentiality.

Finally, Participant 9 remarked on the advantage of not having a specific obligation to provide any particular mental health service as an advantage:

> We don't have to feed people, we don't have to find them houses, we don't have to manage their money, we don't have to make them take their medications. There's nothing we have to do. So we have what I refer to as the potentially therapeutic freedom to do nothing.

While ministers were regularly approached for support for suspected mental illness from members of their communities, they never described being an individual's sole resource. Often, people who came to see them for mental illness were either already seeing a formal mental health care professional or the minister would help them engage one or more of these professionals, while continuing to provide support for the individual. Further to the support they could receive from all the above-mentioned sources and the ministers, the church community was also available as a network of social support.

3.3.2 *The Role of Community in Mental Health*

Ministers worked closely with the communities they served to encourage development and growth while respecting the existing community culture. Ministers described the welcoming environment that they encouraged within their communities and its importance to individuals living with mental illness. Ministers also discussed how behavioural problems resulting from mental illness presented a challenge to their community as a whole, how they overcame them, and ultimately how confronting these issues may have benefited the community as a whole.

An important theme that ministers frequently mentioned was creating a sense of welcome for everyone in their church community. Some ministers even described their churches as being known for their sense of welcome. Others noted that they perceived a widespread need for a place where people could feel love, acceptance, and understanding: Participant 10 commented: "A lot of people are looking for a place to be where someone loves them." Participant 5 used the case of an individual suffering from a severe mental illness to illustrate the importance that

community can play in supporting recovery from mental illness: “The church gave her a context where she could re-engage to become much more herself again.”

Ministers regularly reported challenges that the community encountered trying provide a welcoming atmosphere to everyone. Ministers described highly disruptive behaviour from some members of the community with a suspected mental illness. This behaviour ranged from making coffee on the communion table during a service to directing the choir to simply making other congregants uncomfortable during conversation. Many of these usually socially unacceptable behaviours were perceived as harmless, and thus (though somewhat disruptive) were simply ignored, but allowed to continue. Other times, ministers mentioned asking disruptive individuals to leave the service for a short period – however no ministers ever reported banning anyone in a permanent way for unusual behaviour. While ministers reported that their church communities worked hard to maintain a welcoming environment, Participant 7 questioned what level of disturbance should be tolerated by a congregation: “. . . Where do you, when those mental health issues have a negative impact on the community, say ‘no’ ?” Participant 1 spoke of a congregant who was quite disruptive, and was considering asking the member to “dial it back a bit”, when the member confided in them: “This is the only place I haven’t been rejected.” Even though the behaviour continued to be bothersome, the community ultimately chose not to address it so that they might preserve that congregation member’s sense of welcome.

Although several ministers noted the challenges of maintaining a welcoming environment, one minister also noted that there were also some benefits. Participant 3 noted that when the community prayed for an individual in crisis, it was not only helpful to that person, but also helpful to the community that prayed. The act of praying for someone in crisis provided a sense of support to the church community as a whole; it provided reassurance that should one of them ever experience a similar crisis, they would receive similar support and care. While

welcoming individuals with mental health problems into their communities presented certain challenges, there were also clear benefits.

Finally, the context of community offered ministers a unique opportunity to interact with community members in an informal setting. During community activities Participant 7 noted that ministers could interact with and observe members of the congregation: ". . . Every Sunday after church there's a coffee time when people get together . . . you zero in very quickly that somebody may have some particular psychiatric issues that are going on, that may not be obvious to anyone else." Overall, the church community itself offered important opportunities for interaction, additional support and understanding of an individual's needs. Although ministers reported that it was often challenging incorporating people with mental illness into their community, it also had the potential to be a rewarding experience to the community as a whole.

3.3.3 *Accessibility of Ministers*

Ministers in this study described being regularly approached by both members of their congregation and members of the general public for help with symptoms of a suspected mental illness. In addition to there being less stigma associated with speaking to a minister compared to a formal mental health care professional, ministers described themselves as being more accessible. Ministers were very accessible in terms of both availability and financial cost when compared to formal mental health care professionals. Also, a minister is a highly visible member of a community. A set appointment time is not required to see a minister, and they are available with certainty almost every Sunday. Participant 6 noted: " . . . We have more touch points, right, because we're not in a clinic. It can just be done somewhat informally." Participant 3 described

intentionally making themselves visible and available to approach for people with mental illness: "I do intentional loitering . . . So you just kind of hang out and see who approaches you . . ."

Although they can be approached for the same reason one might approach a formal mental health care professional, Participant 6 noted that the way in which they are approached is unique: "I don't think they approach me the same way they approach a doctor. I think if you're going to your doctor, you go, 'I have a problem . . .' [When they approach me] it often comes in a narrative form." The absence of a set appointment further invites the expression of the problem in the form of a narrative. Usually, an interaction with a formal mental health care provider is limited to a 15-30 minute appointment in a closed office. In contrast, a minister does not have to strictly limit their interaction with congregants in terms of time or location. Participant 8 commented that they were the last of the professionals who still do house calls.

Unlike the formal mental health care professional/patient relationship, ministers see members of their congregation on a regular basis, and have a fundamental understanding of a person's context before they are even approached for help with a problem. Further, because of these casual interactions, ministers have in depth knowledge over a long period of time of many of the individuals in their congregation. This knowledge can provide important context when offering assistance to an individual with a mental illness. For example, formal mental health care professionals often lack or misunderstand important information about the individual. Participant 6 made the interesting observation: " . . . At some point there's a disconnect between, you know, what records show and how a person's life has really unfolded."

Although ministers reported being more accessible than formal mental health care professionals, they still reported time and financial constraints as barriers when supporting someone with a mental illness.

3.3.4 *Time and Financial Considerations*

Ministers described functioning as advocates, long-term emotional support, or interim support while people suffering from suspected mental illness were waiting for access to formal mental health care professionals. Ministers frequently cited their most significant challenges as limitations in terms of time and financial resources (of both the church and of the individual).

Participant 7 described being limited in their ability to deal with mental illness in their congregation in large part by their own availability:

> I cannot see everybody who walks through this door who wants a half an hour or an hour of my time. I would never do anything but sit there and just have people talking at me about anything and everything.

Participant 10 said: " . . . At some point, it also becomes a burden. Like some of them would come every week." Although not strictly bound by set appointment times or patient quotas, ministers have many other obligations beyond providing services relating to an individual congregant's mental illness. Ministers protected their time by working with volunteers to better meet the demand for support services, limiting the number of private sessions they might see someone regarding the issue of mental illness, referring on to specialists, and identifying attention-seekers.

Closely related to the challenge of time are financial challenges faced by both ministers and members of the congregations. Participant 3 said: "The main big challenge right now is financial." Participant 3 attributed the financial difficulties faced by the church to the older generation dying out, and that the younger families replacing them do not have the financial ability or the commitment to the church to contribute financially as previous generations did. Beyond the churches' own limited financial resources, in many cases the financial resources of the people affected by mental illness were limited as well. Participant 1 noted:

> I think one of the biggest barriers is financial cost of the therapy. There's very little that's covered by medical care. . . . But most psychiatrists either deal with meds, because that's all they've got time to do. If you just need someone to do talk therapy and you don't have the money to do it, it's really hard. And even most insurance plans don't cover much. . . . So that's a major barrier for a lot of people . . . and often people with mental health problems end up falling through the cracks. Can't always hold a job, and so they don't have the money to pay for therapy. Yeah, that's the hardest part, the biggest barrier I can think of.

All ministers who participated in this study recognized financial and time limitations as significant barriers. Perhaps a more subtle, but certainly just as significant barrier to providing services to people with mental illness was ministers' confidence in their colleagues' ability to similarly provide appropriate and beneficial assistance.

3.3.5 *Ministers and Their Colleagues*

The majority of ministers spoke of doubts they had in their colleagues' knowledge and ability to deal with problems related to mental illness. Participant 8 said, "Most clergy, I don't think should be counseling anyone. I don't think they have the training and the background." These doubts were regularly expressed both with regard to clergy representing different denominations within Christianity and other religions, but also of ministers in the United Church. Referencing understanding of mental health, Participant 2 said: "I think for the most part ministers would be not that far different from the more informed general public."

While ministers shared many examples of how religion benefited people struggling with mental illness, they were also wary of how religion could be damaging. Participant 10 said:

> You know, there's some really bad religion out there too. You know it's like if you just pray hard enough . . . but there's a lot of bad stuff out there and there's people, like ministers are sot of the last vestige of sort of this Jack of all trades or Jill of all trades, where we need to be counselors, we need to be good creatures, we need to be administrators. So not all of us are good pastoral care givers.

Notably, all ministers interviewed for this study expressed confidence in being able to offer some form of help to individuals experiencing mental illness.

Several ministers expressed concern for how their colleagues, within the United Church, other Christian denominations, and other religious communities, might deal with mental illness. Participant 7 felt that because of previous experience in mental health, they might be more at ease when confronted with mental health issues than some other colleagues within the United Church. Participant 1, while speaking of how the United Church and its members are taught to recognize their boundaries and limitations particularly with regard to providing mental health support, acknowledged: " . . . Not all my colleagues are good at that [acknowledging boundaries]. . ."

Further to their concerns regarding their religious colleagues, many ministers in this study alluded to or directly addressed the issue of prejudice from formal mental health care professionals. Participant 7 summed up the nature of the prejudice and the understandable reasoning behind it:

> You know, we're not responsible for somebody hearing demonic voices. Now, having said that, I mean there are traditions out there who do some very weird things . . . There are traditions around today that would see somebody with a mental health issue and see that the solution to that is prayer.

Many ministers acknowledged that formal mental health care professionals have good reason to be hesitant with regard to referring a vulnerable person out to a clergy member of unknown quality or intention. Participant 6 speculated: " . . . I think ministers are highly distrusted because some of us are extreme personalities, I guess." Also, a high degree of cultural sensitivity is required when dealing with religion. For example, a non-practicing Muslim formal mental health care professional may have some idea of where to refer a Muslim patient for spiritual and religious care, but may not have any idea where to refer a Buddhist, Christian, or Catholic patient.

Ministers continually emphasized their limitations in terms of being a resource for people experiencing symptoms of suspected mental illness; one of the most frequent concerns ministers cited with regards to their colleagues was if they were aware of the limitations of their expertise. Though participants expressed concern regarding their colleagues within the United Church, they tended to have more concern for their colleagues in other denominations. Participant 6 said:

> And I think that happens less in the United Church, but more in some other denominations. So I have had colleagues in the community in other places that are where I would have stepped out long before, or tried to make referral, or would really understand it as a psychiatric problem – they would be much more involved with the person. Trying to heal them or cure them or . . . which I get uncomfortable with.

Ministers also spoke generally of their need to recognize the limits of their own expertise. Participant 2 said:

> Well, I may not be helping you. I could be doing more harm than good. We need to recognize where our capabilities and our training lie and to be absolutely sure that we are not getting into places where we should not be.

Chapter 4: Discussion

At its inception, this study was largely exploratory in nature due to the lack of research done in this area involving the United Church of Canada. The results of this study confirmed that ministers in the United Church were regularly confronted with scenarios usually associated with formal mental health care professionals. These findings were in agreement with existing literature conducted in other regions and in different religious communities (Abu Raiya & Pargament, 2007; Weaver, 1995; Young et al., 2003).

Ministers in this study largely considered themselves as a one-way bridging service while individuals were waiting for access or unable to obtain other services related to mental illness. Although regarded as separate from formal mental health care professionals, ministers are generally regarded as front-line mental health workers (Weaver, 1995). The findings of this study further elucidate the role of clergy in the contemporary informal mental health care network.

Another important type of support that ministers provided was being able to address concepts of guilt and shame in mental illness from a religious perspective. Research shows that individuals who have a tendency towards religiosity also tend to experience more feelings of guilt (Luyten, Corveleyne & Fontaine, 1998). Participant 4 mentioned that releasing people from their guilt and shame was something they could do as a minister. They can also directly address concepts such as “right” and “wrong”, concepts not really acknowledged by formal mental health care professionals.

Perhaps the most significant theme that arose was also the most common: ministers felt it important that they clearly distinguished their role as a spiritual leader

from that of a formal mental health care professional. As in a previous study by Mathews (2011), the ministers who participated in the present study, though they were well educated and informed in regards to mental illness, reported referring individuals without hesitation to formal mental health care professionals for more specialized support. Ministers in the present study were cautious not to become involved situations that demanded skills beyond their ability. This study drew exclusively from a sample of ministers of the United Church of Canada, well known for its liberal political and social views. A very different outcome might be the case if more conservative branches of Christianity or other religions were examined.

There is a great deal of stigma still associated with seeking help for a mental health problem. Aside from being a barrier to treatment-seeking, stigma can have its own negative effects on people of mental illness (Livingston & Boyd, 2010). Estimates range from as little as only 11% of people with a clinically significant symptom of a mental illness seeking help from a formal mental health care professional, perhaps in large part due to the stigma associated with mental illness (Vogel et al., 2007). Ministers acknowledged this challenge for formal mental health care professionals, and many ministers reported actively working to dispel this stigma through a variety of means, with Participant 1 even going so far as to be very open about their own struggle with mental illness. By continuing to address issues of mental illness through services offered by the church, addressing the topic of mental illness in sermons, welcoming individuals with severe mental illness into the community, and actively seeking out individuals who might be experiencing a mental illness, ministers contributed to combating the stigma associated with mental illness.

Beyond clergy consistently making referrals to formal mental health care professionals, this study found little evidence of collaboration between urban ministers and formal mental health care professionals. This finding was consistent with the limited current literature. A 2003 article described the author's experience of working as a clinical psychologist in a Methodist church-based counseling ministry in the United States (David Spriggs, 2003). The author commented how collaborating with clergy when providing treatment for mental illness (with the express written consent of the client) was helpful in terms of better understanding a client's context (David Spriggs, 2003). The results in this study directly support these findings. There is general agreement throughout the literature that increased clergy collaboration with formal mental health care professionals would ultimately benefit individuals living with mental illness (Abu Raiya & Pargament, 2010; David Spriggs, 2003; Edwards et al., 1999; Mathews, 2011).

One of the common barriers to collaborations between clergy and formal mental health care professionals cited by the literature was the difficulty in establishing a bi-directional and trusting relationship (Benes, Walsh, McMinn, Dominguez & Aikins, 2000; David Spriggs, 2003; Kramer et al., 2007). While many ministers in this study reported that they were generally treated with wariness when dealing with formal mental health care professionals, ministers acknowledged that though this attitude was regrettable, they found it understandable and perhaps necessary to protect against "the bad religion". This recognition and understanding of some of the prejudice ministers experienced when attempting to initiate collaboration is an important step to facilitating formal collaboration.

There has been mention of concerns regarding delaying or avoiding formal mental health care professionals in favour of treatment by clergy for mental illness (Wang et al., 2003). Contrary to these concerns, another study found no significant difference in prescription medication use for symptoms of a mental illness according to the frequency with which they attended a worship service (Harris, Fallot, & Wolfson Berley, 2005). Evidence from the present study corroborates the findings from Harris et al., as ministers who participated in this study largely reported positive attitudes toward medication and formal mental health care professionals. Further to the study's finding that ministers did not discourage the use of formal mental health care professionals, ministers in this study in fact helped to promote treatment compliance and often reported making referrals to formal mental health care professionals.

Innovative collaboration (largely in hypothetical scenarios) is examined briefly in the literature (Edwards et al., 1999; Lish, McMinn, Richelle Fitzsimmons & Root, 2003). Perhaps the most innovative, recorded example of interdisciplinary collaboration arose spontaneously from two separate interviews included in this study. Two separate ministers reported being involved with a medical team who approved (and in one of the cases, requested) the therapeutic application of an exorcism ritual. Although this scenario is unlikely to become commonplace, it certainly warrants a study unto itself. In both cases, the individual showed marked improvement after the performance of the exorcism ritual. Both ministers involved commented that it could not be determined if the exorcism was truly responsible for the patient's recovery, as they may have recovered without intervention, medications previously and concurrently administered during the ritual could have been responsible, or the improvement could have been due to the placebo

effect. The importance of this type of collaboration is that while virtually every other treatment option had been exhausted, this relatively simple and cost-effective treatment was applied with a good outcome. The author of this study was unable to find any similar account in other peer-reviewed literature.

There is evidence in the literature and the findings of this study that clergy hold an advantage over formal mental health care professionals because of the trust placed in the profession itself (Kloos, Horneffer, & Moore, 1995). Further, clergy may be able to bridge the perceived cultural gap between formal mental health care professionals and the general public (Kramer et al., 2007). Ministers who participated in this study supported these assertions during their interviews and generally described being perceived as trustworthy. By fostering and encouraging collaborations between ministers and formal mental health care professionals, it may be possible to increase the proportion of people with mental illness who seek help. Based on the results of this study, ministers may be an underexploited resource when dealing with mental illness.

Ministers reported that operating within a community setting, rather than an office with a closed door, was very helpful in terms of meeting people who otherwise might not actively seek help. Ministers in this study recounted using community activities to casually observe people for signs of mental illness. This is an invaluable service, as there is a significant disparity between service use and service need (Kohn, Saxena, Levav, & Saraceno, 2004). In addition to helping to bridge this gap in formal mental health care, ministers also have the opportunity to reduce social stigma and isolation related to mental illness. Ministers in this study accomplished this by addressing mental illness as a topic in their sermons, being open about their personal struggles with mental illness, and

fostering an environment of tolerance and acceptance. Previous studies have lent support to this finding. A positive correlation exists between mental health and social support, while social isolation and stigma have been credited as contributing to the exacerbation of several aspects of mental illness (Cohen & Ashby Wills, 1985; Corrigan, 2004).

Accessibility is a significant barrier to obtaining mental health services from formal mental health care professionals. Accessibility is determined by financial accessibility, physical accessibility, availability, and whether the individual considers the treatment acceptable (Stefl & Prosperi, 1985). Ministers reported themselves as more accessible than formal mental health care professionals. Ministers reported that they were more accessible because they did not charge a fee, and they were easily found in their place of work, or through private communication. Also, ministers are available for house calls, while house calls are unusual for a formal mental health care professional. Finally, because ministers typically reported having a better understanding of an individual's context, they might be perceived as being more capable of offering or brokering an acceptable treatment plan.

The two most commonly reported barriers reported in this study by ministers were constraints on their own time and the financial resources of the church. The demanding and stressful schedule of clergy members is well documented in the literature, and demand for assistance with mental illness is increasing (Hills, Francis, & Rutledge, 2004; Jacobson et al., 2012). Other studies examining churches collaborating with formal mental health professionals mentioned financial challenges as well (David Spriggs, 2003; Benes et al., 2000).

Interestingly, the author was unable to find peer-reviewed research on how ministers perceived the abilities of their colleagues to participate in the treatment of mental illness. Most ministers interviewed for this study expressed doubts of how well their colleagues might be prepared to offer intervention when approached by someone with a mental illness. These concerns were voiced regarding both colleagues in other religious groups and colleagues in the United Church. Indeed, one study found that that the average clergy member has approximately the same knowledge regarding mental health as students in an introductory undergraduate psychology class (Domino, 1990). Although previously unrecognized in the literature, this finding is highly significant. It demonstrates the lack of consistency in clerical training, to the point that even a seemingly uniform sampling of ministers questions the abilities of their colleagues.

Given that Quebec culture has been noted for its anticlerical attitudes since the Quiet Revolution began in the 1960s, it would be of importance to consider that if this study were conducted in other provinces throughout Canada, radically different themes may emerge (Magnuson, 1980). Perhaps elsewhere in Canada, more reciprocity would exist in relationships between formal mental health care professionals and clergy, thus further facilitating innovative collaboration.

In sum, collaboration between ministers and formal mental health professionals is a logical evolution for our current model of mental health care. This generation of ministers is very empathetic and attracted to psychiatry. Ministers in this study clearly appreciated the role formal mental health care professionals, and were interested initiating formal collaborations to optimize treatment.

Chapter 5: Conclusion & Future Directions

Ultimately, the role of ministers in mental health is a significant one, despite the role being largely undefined in the United Church, and even disregarded by many formal mental health care professionals. There is great potential for improved resources, treatment support, and accessibility for people with mental illness if ministers are welcomed and actively engaged as collaborators by formal mental health care professionals (Koenig, 2004; Young et al., 2003). Currently, ministers in this study and others have described informally serving several functions, including: connecting with and identifying at risk individuals (who might otherwise go unnoticed), fostering a socially supportive and tolerant environment in their congregation, providing additional support, and encouraging treatment adherence.

Beyond time constraints and financial limitations, the most significant barrier apparent from this study is simply the challenge of collaborating with formal mental health care professionals. A first step to addressing this problem would be to create an open dialogue between formal mental health care professionals and ministers. The United Church is an ideal denomination with which to initiate this collaboration for two reasons: they are one of the largest religious denominations in Canada, and considering the findings of this study, the United Church would be open to collaborative relationships with formal mental health care professionals. Additional training and workshops on mental illness might also be of interest for career development to clergy in various denominations, and additional training in culture and world religions might be helpful to formal mental health care professionals.

Though there is increasing interest in research regarding spirituality and mental health, there is a relative paucity of Canadian research in this area. In future studies it would be important to expand the sample to include not only other denominations within the Christian religion (such as Catholic, Pentecostal, and Anglican), but to also include other major religions represented in Canada, such as Judaism, Islam, Hinduism, and Buddhism (to name a few).

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Appendix A

Glossary of Key Words

Clergy: A religious professional, ordained to perform religious functions.

Formal mental health care professional: This title refers to professionals typically associated with providing services for people with mental illness: general practitioners, psychiatrists, psychologists, and nurses.

Mental illness: Health Canada (2006) describes mental illness as a condition that can affect a person's mood, behavior, or can result in a disturbance in thinking. Conditions such as anxiety disorders, personality disorders, mood disorders, eating disorders and schizophrenia are considered in the terms mental illness.

Minister: A religious professional in the United Church, ordained for religious functions.

Spirituality: Spirituality has an ever changing definition (Koenig, 2008). For the purposes of this document, the term spirituality encompasses all religious practices, from formal and organized religious observances to superficial or non-specific activities or beliefs related to a power greater than oneself.

Support: This term is used as general term, usually to describe care that clergy provide. It is used to distinguish between the treatment and counseling that formal mental health care professionals provide their clients.

Appendix B

Topic Guide:

1) Tell me about your congregation.

2) Tell me about your experiences with issues of mental health and wellness in your congregation.

3) Tell me about challenges you encounter when dealing with these issues.

4) What kinds of resources do you use to overcome these challenges?

5) When faced with a congregant with a severe mental health issue, what might you suggest?

6) Are there particular passages or scriptures you refer to when advising someone with a mental health issue?

7) Why do people choose to approach their minister for a mental health issue?

8) Is there anything else you would like to tell me?