A Cooperative Inquiry:

An investigation into the training needs of Christian leaders supporting congregants with mental health issues receiving treatment.

by

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Contents

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Abstract

The research literature suggests that NHS mental health service providers question the helpfulness of Christian leaders in caring for congregants with mental health issues. The lack of appropriate mental health literacy training means that Christian leaders find it challenging to collaborate with mental health professionals regarding their congregants' care. However, congregants often seek support from their Christian leaders without additional contact with mental health professionals. The research aim was to identify Christian leaders' training needs in order to develop a curriculum that addresses those training needs and fosters greater collaboration with NHS mental health services.

The study utilised a cooperative inquiry methodology to explore fifteen Christian leaders' experiences of providing mental health support for their congregants. They came from different denominational and ethnic backgrounds. It also explored their relationship with mental health services. Bourdieu's concepts of field, habitus and cultural capital offered a powerful 'theoretical lens' for exploring and conceptualising the tension between the medical world of psychiatry and the religious world of the Christian leaders.

The findings suggest that these Christian leaders find themselves ill-equipped to work within what they experience as the 'hostile' NHS mental healthcare services and the uncomprehending structures of their churches. Christian leaders felt silenced, isolated, and seen as the problem. Cultivating a new skill is essential if Christian leaders are to meet their congregants' mental health needs.

The researcher's contribution to knowledge is to identify a fundamental theological issue and then develop a curriculum that equips Christian leaders to 'mingle' with mental health professionals in the NHS by acquiring the knowledge and language necessary to support congregants within this context. The research suggests contextualisation as fruitful theological

approach and proposes public theology as a way forward that will enable Christian leaders to communicate effectively within the field of mental healthcare. They will, thereby, be better able to support congregants, and form a stronger partnership with the NHS mental health services.

Abbreviations

CI	Cooperative Inquiry
GP	General Practitioner (family doctor)
MH	Mental Health
NHS	National Health Service

Chapter 1 Introduction

1.1 The nature of the investigation

This research uses cooperative inquiry methodology to investigate the training needs of Christian leaders caring for congregants with mental health issues who are using NHS services. The inquiry involves two groups of Christian leaders in the south east of England to explore this research question:

> *What are the training needs of Christian ministers so that they are better equipped to fulfil the spiritual and pastoral care needs of members of their congregation with mental health issues? The insight from this research will provide a curriculum for the training of Christian ministers.*

I met four times with each group to explore their experiences of their pastoral encounters with congregants. This introduction offers the reader an initial rationale for the study which utilises Bourdieu's concept of habitus, cultural capital and field to identify its contribution to knowledge.

A number of researchers in this field (Ellison *et al.*, 2006; VanderWaal *et al.*, 2012; Weaver, Koenig & Larson, 1997; Young, Griffith & Williams, 2003, cited in Payne, 2013; Wood, Watson & Hayter, 2011) suggest that church leaders help congregants with mental health problems and their families on a daily basis. The prevalence of mental health issues in churches has raised concerns as to how church leaders respond to these problems, and some studies have questioned the nature of their involvement (Leavey, Loewenthal & King, 2007). Do Christian faith community leaders have enough mental health knowledge and training to address the current challenges? Should their involvement be of concern to the mental health service?

According to Leavey *et al.*, in the United Kingdom,

> the evidence as to the capacity, confidence, and willingness of faith groups and clergy to engage in this care is unavailable (Leavey *et al.*, 2012, p. 385).

However, they are often front-line responders in community mental health care (Kramer *et al.*, 2007).

1.2 Personal and professional rationale

As a pastoral counsellor, a man of colour and Pastor of a local Christian church, pastoral care for congregants with mental health issues is personally significant. This study will demonstrate that despite sincere attempts to support congregants with mental health problems, clergy are largely unprepared to meet the mental health needs of parishioners (Bledsoe et al., 2011). As a pastor and mental health chaplain working in the NHS it became clear to me that care for congregants with mental health issues needed more than listening and offering biblical quotations to support congregants. Watson and Hayter (2011) suggest that there is no adequate training for Christian leaders interested in mental health issues. Weaver (1995) argues that lack of education leads to a lack of understanding about the help that Christian leaders could offer congregants in mental anguish. As a Christian leader, theological reflection on the problems presented requires sophisticated understanding of the mental health experience. Therefore, in a Church context, relying on biblical text alone to guide troubled congregants is inadequate (Hiltner, cited in Woodward & Pattison, 2000).

I developed the idea for this study in response to the question of Christian leaders' readiness to undertake the mental health care of congregants (Leavey, Loewenthal & King, 2007; Leavey & King, 2007; Durà-Vilà *et al.*, 2011), with the view to developing a curriculum that addresses some of their training needs. This research will contribute to knowledge by addressing this knowledge gap - providing training that addresses Christian leaders' needs is vital to supporting congregants and improving their relationship with the mental health services in the NHS.

1.3 Why investigate Christian leaders dealing with congregants with mental health issues

The relocation of mental healthcare from big institutions into the community is sometimes referred to as 'deinstitutionalisation', which is a philosophy of mental healthcare in the community (Fakhoury & Priebe, 2007). This has brought new challenges for faith communities and Christian leaders. According to Gilburt *et al.* (2014) and Leavey, Loewenthal & king (2007), the transfer of psychiatric care into local communities has presented faith communities with an extra burden and responsibility of care. The concern for those with mental health problems living in faith communities is that they often find themselves seeking help from ministers who can be afraid to engage, or not sure how to respond to their needs. Christian pastors can find themselves inadequate to offer appropriate care for congregants with mental health issues. Domino (1990), Holmes and Howard (1980), and Leavey, Rondon, and McBride (2011) (cited in Leavey, *et al.*, 2011) suggest that a Christian leader's feeling of inadequacy is due to a lack of insufficient training in mental health issues. Leyshon (2002) indicated that in his work as a Christian leader he regularly met congregants with mental disorders, but the usual pastoral interventions were not helpful to such church members and he needed to learn how to respond to such conditions.

Similarly, most Christian ministers considered their seminary training to be lacking in an understanding of mental health problems (Payne, 2013). Weaver (1995) reported that a church minister is inadequately prepared to deal with severe mental issues. A congregant who is seeking help and advice from the clergy does so without additional contact from professionals, and there is no data on the efficacy of whatever it is the Christian leader provides (Leavey, Dura-Vila, & King, 2012). The literature suggests that "clergy are largely unprepared to meet the mental health needs of parishioners" (Bledsoe, *et al.*, 2011, cited in Payne, 2013). According to Copsey (1997) most faith leaders would either seek assistance from a mental health chaplain or avoid the problem altogether due to a lack of skill in the area of mental health pastoral care.

This situation is unhelpful, as mental health care in the community offers Christian leaders the opportunity to be partners in the care of congregants. According to Chapman (2012), government departments and public and non-statutory agencies request the inclusion of faith communities as partners in health and welfare services. The FaithAction report (2017) suggests that health promotional activities should work through, and in cooperation with, faith-based communities as these religious institutions have many unique resources, cultural and social capital, and information about the local community to help with access for vulnerable people.

A study by Leavey, Loewenthal, and King (2007) which examines the barriers and dilemmas of Christian pastors, rabbis and imams in London caring for people living with mental health problems found that these ministers played an essential but often confined role. However, they stated that,

> low confidence about managing psychiatric problems, underscored by anxiety, fear and stereotyped attitudes to mental illness restrain their willingness to formalise this function. (Leavey, Loewenthal, & King, 2007, p. 558).

The report suggested that any proposed extension of clerical involvement in mental health would require further research and thorough deliberation by mental health services and religious organisations, with a review of their educational programmes (Leavey, Loewenthal, & King, 2007; Payne, 2013).

1.4 Contribution to knowledge

I have conducted this research from the standpoint that Christian leaders and churches have a legitimate place in the care of congregants with mental health needs, and that a contribution from Christian leaders will benefit both the congregants and the NHS that cares for them. The majority of current research looks at the links between spirituality and mental health and the importance of spirituality and religion as positive indicators to good mental health and wellbeing. Fewer studies are looking at the content for training pastors who care for the mental health needs of their congregants. My investigation uses

Bourdieu's theoretical framework to address these training gaps by providing a research basis for and suggesting a curriculum to enhance the mental health training of Christian leaders. So this investigation is well situated to make an essential contribution to knowledge in this currently under-researched field.

This research study will add to the growing body of knowledge in the area of pastoral care and mental health. It will bridge the gap between practice and theory for Christian leaders in the field of psychiatric care, and offer the opportunity to improve ways that Christian leaders care for congregants with mental health issues.

1:5 The thesis structure

Chapter 1 provides an overview, context and rationale for this study, outlining both my personal and professional interest in this area and the need for Christian leaders involved with congregants with mental issues to be adequately trained.

Chapter 2 provides the essential aspects of the historical background to highlight the relationship between the Christian Church and mental health care. I argue that faith-based organisations and their leaders are significantly involved in the lives of their members, including those with mental health issues. However, congregants will continue to struggle with the support their leaders offer due to inadequate education in mental health issues, and a lack of competence in the causes and treatments of mental illness.

Chapter 3 discusses the ontological and epistemological considerations that underpin the research. The researcher adopted an interpretive, constructivist position to obtain the knowledge needed for the study, so as to understand the complex world of the lived experiences of my participants, who lived it. My research considers and makes a case for using cooperative inquiry methodology. The chapter explains the methods, the critical decisions about participants' recruitment process, techniques for data collection, and the steps taken to demonstrate trustworthiness, followed by a final discussion of the ethical considerations with the participants.

Chapter 4 outlines and discusses the principal theory of the study. My research utilises the analytical framework of Bourdieu's (1977b, 1990) concepts of field, habitus and cultural capital to understand, explore and conceptualise the tension between the medical world of psychiatry and the religious world of Christian leaders.

Chapter 5 constitutes the analysis of the data and the consequent findings. This chapter covers the research analysis and findings of fifteen participants, four from group Southeast 1, and eleven from group Southeast 2. The study uses a combination of thematic analysis (Braun & Clarke, 2006) and Bourdieu's (1977b, 1984, 1990, 1997) concepts of habitus, cultural capital and field to provide the theoretical lens for the analysis.

Chapter 6 categorises and discusses the findings. The four main categories are an amalgamation of the conclusions of the two cooperative inquiry groups. They are:

1. Helping the unwilling to become willing
2. The legitimacy of faith responses to mental health
3. The silencing of the faith response
4. Mental health literacy

The chapter draws on Bourdieu (1977b, 1984, 1990, 1997) to explore and interrogate the relationship between Christian leaders, congregants, and the professional mental health practitioners. This is to determine how religious and mental health fields relate to provide ideas that support the training needs of Christian leaders. The chapter concludes that Christian leaders, confident in the church habitus with skills, experience and intellectual and spiritual resources sought after and recognised by congregants, find themselves ill-equipped to operate within the habitus of medicalised mental healthcare. The results of the study invite the Christian leaders to a theology that is welcomed by both the congregant and mental health professional in the NHS that cared for them.

Chapter 7 discusses the implications of the study. The first part suggests that Christian leaders do not need to become trained counsellors, psychologists or

psychiatrists to care for congregants with mental health problems. Instead, they need to be helped to understand how to incorporate their unique religious and spiritual knowledge within a framework that recognises their distinctive contribution to the mental health field. The research suggests a paradigm of Christian engagement, a contextualisation as a way of making the Christian leaders' ministry relevant to the context of the mental health field of the NHS. The researcher proposes public theology, a form of applied and practical theology, to enable communication within the field of mental healthcare.

The chapter offers a specific and substantive theological reflection on issues of prayer and demon possession to support Christian leaders in their pastoral care of congregants. It provides a detailed curriculum that addresses the findings of the research. The chapter concludes with a reflection on my EdD experience which has been a journey, a new chapter that has positively impacted on my professional role and has given me a greater sense of professional identity.

Chapter 2 Literature review

2:1 Introduction

A collection of journals and other academic literature, and those from psychiatry, medicine, nursing and other humanities indicates the growing interest in religion/faith and mental health care (Cornah, 2006; Koenig, 2012; Swinton, 2001). Research findings from a series of cross-sectional and longitudinal research studies by Ellison and Levin (1998, cited in Thoresen, 1999), Koenig (1997, cited in Thoreson, 1999), Larson *et al.* (1998, cited by Thoresen, 1999) and Levin (1994, cited by Thoreson, 1999) showed a positive relationship between the practice of religion and good mental health and well-being outcomes. "Spirituality has been found to be an important component in the recovery of severe mental illness" (Corrigan *et al.*, 2003, cited in Forrester-Jones *et al.*, 2017). The experiences of people of the Christian faith using the mental health service have emphasised the positive impact their belief has on their mental health, which they say are pertinent to their mental wellbeing and a significant aspect of their recovery (Raffay, Wood & Todd, 2016).

However, some patients may believe that seeking medical advice or taking medication suggests a lack of faith in God's ability to heal the disease without medical intervention or disobedience to religious doctrine (Zagożdżon & Wrotkowska, 2017). The evidence suggests that lack of treatment adherence because of religious reasons is a serious issue in mental health care (ibid). The medical model is seen by religious patients as misjudging their spiritual needs (Morgan, 2017). These facts of spiritual care are compelling, but it may still be difficult to include them within patients' treatment as it influences medical treatment (Forrester-Jones *et al.*, 2017). Christian leaders continue to address the mental health needs of their congregation, their positive involvement has been cited by Wood, Watson and Hayter (2011) and are often seen as the first responders to congregation members with mental problems (VanderWaal, Hernandez & Sandman, 2012). Payne and Hays (2016) suggest that it is essential to understand how the Christian leader handles such issues.

2:2 Brief history of the relationship between the Christian Church and mental health care: collaboration or conflict?

The historical relationship between mental health services and the Christian Church provides the thesis trajectory with a discourse of interaction to understand the tension between the current mental health services and the church. Collaboration and conflict between psychiatry and religion are ongoing, deep-seated, and not a modern phenomenon (Sullivan *et al.*, 2013). Religion, spirituality and medicine collaborated in the care of the ill prior to the Enlightenment period of the 17th and 18th centuries, when scientific and rational theories began to explain the world (Bristow, 2011, cited in Sullivan *et al.*, 2013). The development of medical explanations for illness and behavioural science has continued to push apart the relationship between models of care the church and mental health services provided, causing friction and anxiety between them. The supernatural paradigm of understanding mental disorders dominated Europe during the Middle Ages (Farreras, 2013, p.p. 244-246).

The Christian Church during these periods focused on such explanations and promoted illness as the work of supernatural forces (Koenig, 1998, pp. 3-8). Mental and all illnesses were seen as imposed by God on humans as a chastisement for sin, or understood as God's wrath, or caused by demons (Webb, 2012). Drilling holes into the head of a person with mental illness let out what was believed to be evil spirits (Barlow, Mark and Hofmann, 2018, pp.7–8). Trephining (the process of drilling into the human skull) was common and these stories appeared to be speculative (Fawcett, 2016; Lisowski, 1967). Negative attitudes within the general population towards people with mental health problems were fuelled by superstition which led to a societal and community stigma (Rosen, cited in Foerschner, 2010). The long-standing belief that mental illness was caused by supernatural forces was challenged by early European thinkers. Hippocrates and others proposed that natural occurrences in the human body, particularly pathology in the brain, were the problem (Foerschner, 2010). The historical evidence suggests the

church's role of maltreating people with mental health problems as demonic possession was widely overemphasised and suggested that human and compassionate therapies were carried out by facilities run by faith personnel (Koenig, 2005). The Christian Church did not always show compassion but sometimes perpetrated inhuman practices toward the mentally ill because of the belief in demonic causation (Covey, 2005, p. 110). The positive mental health care of the church has sometimes been obscured by the violent nature of exorcism conducted, and the fear of confinement that accompanied such treatments. Sim (2009) noted that the historical roots of anti-ecclesiastical attitude of psychiatry with the spiritual domain have been because of the harmful effects of some religious groups on vulnerable patients. But MacDonald (1981, pp. 51-171) argued that the clergy-run facilities were the preferred alternative because of their compassionate approach to care.

Documents from the Middle Ages (500- 1500 CE) also showed the Christian Church taking the lead in helping the mentally ill, and by the sixth-century people with mental problems were being cared for in monasteries run by the Christian ministers (Koenig, 2012). In England, the first mental health hospital, the Priory of St. Mary of Bethlehem was established in 1247 in London on the River Thames (Koenig, 2005, pp. 17-39) and after that many hospitals across Europe were constructed. The church retreat houses reported that mental health patients were treated with dignity and respect and provide a 'therapeutic' environment to enable recovery (Bell, 1980 cited in Farreras, 2013 p. 248). Arguably, the most significant contribution was the moral therapy offered by the 'church retreat houses', which valued and treated mental health patients with dignity and respect (Bell, 1980, cited in Farreras, 2013). However, other reviews suggested the moral treatment did not cure patients, instead the patients suffered under a harsh and repressive regime that betrayed its founders' humanitarian ideals (Digby, 1983).

The role of the Christian Church or the clergy has always remained associated with caring for the sick, including those with emotional problems or severe mental health problems (Dein, 2010). Many Christian leaders continue to

positively address congregant's mental health needs (Clebsch & Jaekle, 1994; Higgins, 1992; Leavey et al., 2016; Wang et al., 2003; Wood et al, 2011). Religious belief and practices have been thought to be pathological and considered as symptoms of mental illness (Koenig, 2012). Furthermore, clinicians had raised concerns about the Christian leaders' perceptions and aetiology when caring for congregants with mental health problems (Moreira-Almeida, Koenig and Lucchetti 2014) and claimed the Christian leaders don't understand mental illness and often ignore, overlook or consider it a taboo (ibid, pp. 38-40).

The collaboration between the psychiatric establishment and Christian leaders/church has been marred with suspicion and a degree of hostility (Sims, 2003). This brief historical examination provides a helpful perspective on the context that had influenced and shaped the subtle, and very often passive aggression to the contribution provided by the Christian leaders. It may be seen as one of shared aim, tension, disagreement, and scepticism (Sullivan *et al.,* 2013). Christian leaders may be able to influence the care of congregants by teasing out the complex relationship between themselves, the congregants and mental health professionals.

2:3 The impact of spirituality and religion on mental health issues

Literature from psychology, medicine, sociology, gerontology and education reports on a number of studies examining the impact of religion and spirituality in mental health. The impact of religion on mental health suggests that religion generally, but not always, plays a positive role, religion is a significant factor that enables congregants to manage the stresses of their illness (Koenig, 1997 cited in Sullivan *et al.,* 2013; Thoresen, 1999). Some research findings "suggest that religious belief is a coping resource for patients with the stress of their illness or with dismal life circumstances" (Koenig, 2008, cited in Cook, 2013, p. 7). A study to measure the impact of spirituality and religion on health reported a helpful association between church attendance and low levels of depression among adults, children and young people and a belief in transcendent being and spiritual practices helped

reduced depressive symptoms such as anxiety, stress and other forms of depression (Cornah, 2006). Despite the encouraging evidence of the association of spirituality with good mental health acknowledged by mental health professionals (Cook, 2013; de Zoysa *et al.*, 2014, cited in Forrester-Jones *et al.,* 2017), putting these findings into clinical practice has proved difficult as mental health practitioners are less willing to refer their patients to a religiously based practice (Weber & Pargament, 2014). Swinton (2001, pp. 8-15) argues that spirituality remains a forgotten dimension of contemporary mental health care.

Other studies have suggested a negative impact, these scholars suggested that forms of religious coping can be maladaptive, they argue a feeling of rejection or chastisement by God is associated with worse mental health indices (Dein, 2018). Religious presentation of patients has been understood as pathological in the past (Koenig, 2008).

2:4 Church and clergy attitudes towards mental health

A study reporting on Christian responses towards mental illness suggested that negative attitudes associated mental illness with personal sin and demon possession (Gray, 2001; Loewenthal, 2009; McLatchie, 1984). The perception and concerns of the danger and unpredictability of people with mental health problems hindered meaningful engagements, leaving those with a mental illness feeling isolated and stigmatised (Gray, 2001, pp. 72-75; Varshney *et al.,* 2015). Whilst others felt understood and accepted, a significant number reported negative interactions focused on demons (Almanzar, 2017; Health, 1999; Stanford, 2007). An empirical study with American pastors reported that African American pastors regarded spiritual factors as more important in the aetiology and treatment of mental health problems than their Caucasian counterparts (Millet *et al.,* 1996). Foskett, (1996; Ramm, 1973, cited in Gray, 2001) observed that theological understandings are likely to influence ministers' beliefs around mental illness. Christian leaders have elaborate supernatural or paranormal explanations of mental health illness (Leavey, Loewenthal & king, 2007; Leavey, 2010). A study on a Christian denomination found that their pastors held strong

religious beliefs, had low knowledge of psychology, and attributed the causes of major depression and schizophrenia to religious factors and endorsed demonic aetiology (Hartog & Grow, 2005).

Durà-Vilà (2017) reported that liberal Christian clergy are more likely to be doubtful about a supernatural explanation for mental illness, but the traditional participants considered the devil to be the primary source of illness and anguish. However, "the possibility of mental illness being caused by religion, per se, was rejected by all the participating clergy" (ibid, p. 62). Studies conducted by Lafuze, Perkins and Avirappattu (2002, pp. 900-903) assessing Christian attitudes and practices reported a positive understanding of social and scientific causes of mental illness among 1031 Methodist ministers and medication as an effective treatment (cited in Stanford & McAlister, 2008). A review with 230 Pentecostal pastors on mental illness saw spiritual discipline and faith as an effective treatment option (Trice & Bjorck, 2006). Despite the affinity toward the medical and psychosocial explanations of mental illness, there were also some strong beliefs in demonic possession showing apparent contradiction (Leavey, 2010).

In the last two decades, the Christian Church is becoming more open to conversations about mental health, negative attitudes and more complex theological issues around aetiology and pastoral care remain. Lifeway Research found that 35% of Americans and 48% of those who identified themselves as evangelicals believed that people with severe mental disorders could overcome their illnesses with "Bible study and prayer alone" (Smietana, 2013 pp. 14-15). A survey reported a significant number of mental health patients from the religious churches reported negative interactions with their faith (Foundation, 1997, in Leavey 2010; Stanford, 2007). The attitudes, perceptions, and beliefs about mental illness suggest a mixed and complex nature of the pastor's views about the aetiology, and responses to mental and emotional problems. And a better understanding of the pastor's attitudes and beliefs will help to assess the therapeutic value to individuals who seek their help.

2:5 Training needs of Christian leaders

Given the complex nature of the attitudes and understanding of mental illness by pastors, more information is needed on how pastors offered advice and address the concerns about their efficacy (Young, 2010, pp. 23-33). The Church of England has acted to improve the care of people with mental health difficulties within the church by raising awareness and by providing training and resources for all members (Church of England, 1991). Often this training is seen as ad hoc and not mandatory and is designed to raise awareness and challenge attitudes. However, little is known about its effectiveness. Studies conducted by Young (2010) on pastors who had received pastoral care training, either by workshops or coursework, to degree level in pastoral care or counselling reported needing additional training in mental health. Despite the increase in mental health awareness/understanding courses for clergy and pastors, many of whom went onto additional mental health training, they still struggle with the care of people living with mental health problems in their churches.

A study by DeHaven *et al.* (2004) to find out whether the training and educational programmes designed to address health issues by churches were sufficient and measurable, concluded that there is relatively little evidence base to assess the effectiveness of such training programmes. Pfeifer (1994) argues for training with the aim of combating stigma, negative attitudes and unhelpful perceptions of those living with mental illness. Inadequate education about the causes and treatments of mental illness is partially responsible for the pastor's lack of ability. My participants in this study do not feel that their seminary training provided adequate training in mental health. McRay *et al.* (2001) reported that the priesthood has little interest in learning about psychological skills in assessment or consultation, reflecting a lack of interest in a significant potential area of collaboration. Wood, Watson and Hayter (2011) identified poor clergy knowledge and failure to recognise mental illness affected pastoral care, "it is only those clergy who have had personal-familial experience or with professional training who appear to have a more relaxed relationship with their members with mental health problems"

(Leavey, Loewenthal & king, 2007 p. 552). Commonly, pastors with little or no training in mental health problems as part of the ministry formation were less involved with the mentally unwell (Leavey, Loewenthal & King, 2007). Clergy reported their lack of skill in therapeutic intervention and practice and complain of the pressure to deliver a service they have not had adequate training for (Croft, Barnes & Ginnis *et al.,* 2013; McMinn *et al.,* 2005, cited in Hall & Gjesfjeld, 2013;).

The increased recognition of the significant pastoral role of clergy as mental health caregivers (Weaver, 1995) and the relative dependence by their members for guidance and advice (McRay *et al.,* 2001) places mental health care at the centre of pastoral training. Oppenheimer, Flannelly, and Weaver (2004) conducted a search on the psychological literature to get a better understanding of collaboration between clergy and mental health professionals in providing care. They identified that partnership between the medical staff and the clergy was essential to the front-line/gatekeeper role played by the clergy. However, they asserted that the clergy need more education and knowledge to understand obstacles to cooperation, the importance of shared values, the benefits of collaboration, and their role in early prevention of mental health issues.

2:6 Pastoral support and congregants help-seeking behaviour

Gurin, Veroff, and Feld (1980), Larson *et al.* (1988), Mollica *et al.* (1986) and Weaver *et al.* (2003) all reported on the significant contribution by Christian leaders to the mental wellbeing of congregants. Csordas and Lewton (1998) and Durkheim (2001) suggested that congregants preferred the help of their leaders than from mental health professionals (cited in Leavey *et al.*, 2007, p. 549). Chadda, Agarwal, Singh, and Raheja (2001, cited in Leavey, 2008), Cinnirella and Loewenthal (1999, cited in Leavey, 2008), Cole *et al.* (1995), and Mitchell and Baker (2000), pointed to Christian beliefs about mental illness and other misfortunes as a factor that influenced seeking help and treatment compliance of congregants. Weaver (1995) argues that very little is known either by research or otherwise as to the nature of pastoral support provided by Christian leaders to congregants with mental health issues.

Leavey's (2010) studies on clergy beliefs on mental illness reported that "to some clergy, illnesses may be an element of a broader divine strategy, which is generally not apprehensible by humans and for others the devil is always the source of sickness and suffering" (ibid, p. 575). Pastors have been cautious, reluctant and at times rejected congregants when responding to their pastoral care needs (Leavey, loewenthal & king, 2007, pp. 551-556). Hohmann and Larson, (1993), and Veroff, Kulka and Douvan (1981) reported that non-religiously active people are among those looking for help with personal problems from Christian ministers. Larson *et al.* (1988), Albers (2012, p. 11) and Leavey, Loewenthal & king, (2007) report that seeking help from the priesthood is still prevalent and a considerable number of people seek support from church pastors.

A combination of fear, anxiety, lack of training and resources, as well as stereotyped attitudes about the mentally ill, prevented clergy from expanding and formalising their function further (Durà-Vilà, 2017, pp. 58-60). They were not confident in managing people with mental illness. Despite these limitations, many pastors hesitate to refer people to mental health services (Moran *et al.*, 2005). Thus, many members of the church who present to their leader a severe and enduring mental illness are not referred on to the mental health professionals (Wang *et al.*, 2003). Compromising spiritual direction with a more secular way of helping was a challenge to their religious ethos and theology which could lead to a collapse of, or compromise, their religious distinctiveness; becoming "a social worker in a dog-collar" (Durà-Vilà, 2017, p. 59).

Evidence shows that a significant number of individuals receiving pastoral support from church communities have estranged themselves from their congregations because of beliefs interactions about their disorder (Stanford, 2007). Even so, their faith is a supporting factor and essential motivating coping resource for their mental health (Koenig & Larson, 2001; Harrison *et al.*, 2001). Clinebell and McKeever (2011) suggested that the church should view issues of mental health as an unprecedented opportunity to multiply its contribution to both the prevention of illness and to the therapeutic dimension

of mental health. They advocated a church life which saw itself as a therapeutic and redemptive community that cares and uses the congregation as an instrument of therapy (ibid, 1972, p. 7), so that church members with an emotional problem do not feel lonely, stigmatised and isolated, desperately needing to feel a sense of community with others.

2:7 Partnership and collaboration with mental health institutions

The benefits of greater collaboration between clergy and mental health services have been suggested (Weaver *et al.,* 2003). Concerns about preparedness to co-operate with services and the NHS was raised (Durà-Vilà *et al.,* 2011; Farrell & Goebert 2008; Leavey, Loewnthal & king, 2007; Leavey & King, 2007). Moran *et al.,* (2005) argued that pastors are not in a role that provides the time and context to offer clinical services to people with mental illness. The lack of knowledge and awareness of positive and negative effects of religious belief in mental health will prevent any meaningful collaborative partnerships with mental health services (Leavey, Loewenthal & King, 2007).

Mollica *et al.* (1986) and Ruppert and Rogers (1985) have noted the lack of respect for clergy amongst mental health practitioners. Whitley (2012) suggested that to enhance integration, clinicians should collaborate with faith communities, religious organisations and religious congregations that have shown interest in learning about mental illnesses and demonstrate openness to understanding religious people living with mental illness. He argued further that religious patients with less severe psychiatric disorders should be referred to the appropriate Christian minister, chaplain, or pastoral counsellor for psychosocial and spiritual support to "provide invaluable assistance" (Whitley, 2012, p. 253). Christian leaders' collaboration with mental health services remains a challenge as their role is not clear in mental health and because of the existing mistrust and the ongoing "suspicion of the evidence-based" practice between mental health clinicians and Christian ministers (Cook, 2013; Foskett, Marriott & Wilson-Rudd, 2004; Keynejad, 2008, p. 58; Moreira-Almeida, Koenig & Lucchetti 2014). However, there is evidence to support the increased desire for a better relationship between faith

organisations and mental health services (Cook, 2010; Dein *et al.*, 2010; King & Leavey, 2010). A greater understanding of religion and psychiatry is essential for effective partnership (Verghese, 2008).

Ongoing research on spirituality, religion and mental health has contributed to a collaborative mood in the relationship between religion, spirituality and psychiatry (Lafuze, Perkins & Avirappattu, 2002). The psychiatric discourse and research studies on spirituality have created a new connection between spiritual, mental health practitioners and academics to recognise that spirituality is a relevant dimension in recovering from mental health issues (Carlisle, 2016, cited in Forrester-Jones *et al.*, 2017; Fallott, 2001; Starnino & Canda, 2014). Whitley and Drake (2010) and Pearce *et al.* (2015) have identified religious coping, community and support, the belief system and practices as key indicators of significant contributors beneficial to mental wellbeing.

2:8 Referral pathways: pastoral care in psychiatry

The literature examined acknowledged that adequate pastoral mental health care should be based on knowledge of mental illness and processes (Almanzar, 2017; Lafuze, Perkins & Avirappattu, 2002). Furthermore, because of lack of training and collaboration between clergy and mental health professionals the clergy may lack the competence to care for congregants with complex mental health needs (Hall & Gjesfjeld, 2013; Veroff *et al.*, in Taylor *et al.*, 2000). However, Christian ministers can make a significant contribution to treatment by way of early intervention and early diagnosis (Leavey, Loewenthal & King, 2007). For example, such a significant contribution will prevent people with mental health issues falling through the net as their ministers would put them in touch with treatment services (Schofiels, 1964, cited in Haugk, 1976). The use of Christian ministers in this way, involving the church, will increase the number of people seeking medical help (Clinebell, 1970, p. 46). A Christian minister is a potential referral source in addition to GPs, and also an essential gatekeeper and is in a unique position to facilitate the way for referrals (Croft *et al.*, n.d.).

Ministers may often be able to persuade and assist an individual to seek treatment where a family may struggle to handle such situations.

The evidence in the literature confirms the importance of referrals from Christian pastors supportive of early intervention (Cumming & Harrington, 1963; Gurin *et al.,* 1980; Hollingshead & Redlich, 1958, cited in Haugk, 1976).

The referral behaviour of Christian leaders is influenced by their educational background ((Heward-Mills *et al.*, 2018). Piedmont (1968) and Westberg and Draper (1966) found that Christian leaders who were trained in clinical pastoral education will refer congregants with mental health issues to mental health services. Other studies by Taylor suggested that members of the clergy with liberal theologies are more likely to make referrals to mental health agencies. In contrast, those who endorse conservative beliefs are more likely to attempt to treat people with symptoms of psychiatric disorders by themselves (Taylor *et al.*, 2000). One possible conclusion, therefore, is that Christian ministers need to make referrals to appropriate mental health services. A successful mental health referral is difficult for a pastor without substantial mental health training; and the ability to refer congregants requires developing some understanding of mental illness, emotional and theological needs to facilitate such referrals.

2:9 Pastoral care implications

Theological interpretations of mental illness have been problematic, mainly causing conflicts between beliefs and medical explanations (Leavey, 2010). For example, mental illness seen as demonic activity and other spiritual explanations were controversial among secular medical practitioners (ibid, p. 571). McKenna reported a story from a newspaper about a man with mental health problems believed to be suffering from demonic possession, who went home and murdered his wife after several hours of a deliverance session trying to exorcise him of his demons, (cited in MacKenna, 2012, pp. 4-5). The role of Christian leaders will need mental health insight and practitioner skill if they are to care for their congregants with mental health issues. Moreover,

if Christian leaders have no clear perspective on mental health care, they risk incompetency and less excellent or desirable outcomes (Pattison, 1993). Pattison further pointed out the importance of gaining the correct perspective or critical stance which placed emphasis on the proper way of seeing and appropriate theory as an essential accomplishment to mental health ministry (ibid, p. 3).

For Christian leaders and their communities to offer pastoral support to their congregants, they will need the ability to recognise severe mental illness and develop a willingness to liaise with the medical and psychological services, as well as developing a general interest in contemporary perspectives on psychopathology and how to complete a mental health religious assessment.

The cure of souls (cura animarum; Latin), known as pastoral care, has been a feature of the church according to Pattison (1993). Pastoral care is rooted in religious and theological theory and practice and has been a feature of Christian ministry that guides, heals and sustains its congregants, including those with mental health issues (Clebsch & Jaekle, 1994; Foskett, 2001). Leavey (2008) examined studies of Christian leaders caring for congregants with mental health problems and concluded that pastoral care follows the interest of the individual Christian leader, which depended on the history and theology of the church leader. Often Christian leaders were unsure of the mental health condition of those they have supported (p. 26). Christian leaders without the skills and pastoral sensitivity in mental health care may fail to understand and identify important mental health issues needing a referral to mental health services and may inadvertently risk the care of their congregants.

2:10 Conclusion and summary

The literature reported on the links between spirituality and mental health, the importance of spirituality as a positive indicator to a good mental health outcome as well as on the connection between emotional well-being and religion; but reported less on how congregants with mental health issues are cared for by their pastors and on how pastors are trained to meet the needs of

members of their congregation with emotional health problems. However, clergy and pastors will continue to play a crucial role in mental health care (Wang *et al.*, 2003).

Congregants struggled to find suitable pastoral support and their mental health issues were a spiritual problem. Less research reported on how Christian leaders were equipped to care for their congregants or collaborated with the agencies that cared for them, although Christian leaders were likely to shape and influence the mental health perception of congregant (Stanford, 2007). Therefore, better trained Christian leaders will have the necessary insight to provide pastoral care that is distinctive and addresses the mental health needs of a congregant. Inadequate education on mental health issues, lack of competence about the causes and treatments of mental illness raises questions on how Christian leaders supported congregants.

Training needs of Christian leaders in the area of acknowledging of mental illness, issues around the demonic and spiritual causations of mental illness, collaboration with mental health services and referrals processes, as well as developing a language to show they understood and address the mental health issues of congregants are major themes suggested in the review.

If mental health professionals stay uninformed about congregants' spiritual needs, and equally, if Christian leaders do not feel proficient in addressing congregants' mental health needs, they are ill-equipped. Therefore, for Christian leaders, pastoral skills in mental health care, working collaboratively with mental health providers and knowing when to refer a congregant become significant to training needs (Bonner *et al.,* 2013, cited in Sullivan *et al.,* 2013).

To better understand the efficacy of collaboration, a further study of the relationship between mental health services, Christian leaders and congregants to find out whether the tensions and mistrust could be reduced and thereby improve the treatments for congregants accessing both the mental health service and seeking support from the Christian leader is needed.

Chapter 3 Methodology

3:1 Introduction

To achieve the objective of the study, this chapter will describe the research design and methodology used. A qualitative position suggests that knowledge can be constructed individually and collectively through studying the experience and sense-making of participants, and also in their interaction with me as the researcher to become better informed. The research uses a qualitative methodological design to develop my thinking. This chapter is divided into several sections to explain the research design.

First, I will clarify the rationale of the study and the ontological and epistemological considerations that support this research, discuss my background, explore the power dynamics involved in conducting research and discuss my position as an 'insider' within the research. Secondly, I will explain the methodology and methods used. The third section will explain the processes for data collection and analysis, and the steps taken to demonstrate trustworthiness and reduce biases, followed by a final discussion of the ethical considerations with the participants.

3:2 Rationale

The study aims to identify Christian leaders' training needs (Leavey, Loewenthal & King, 2017), necessary due to the problems pastors face in caring for congregants with such mental health needs, and my personal experience illustrates this challenge. At a morning service in Ghana, a member of the congregation stood up and started to shout, "I am a soldier", marching across the aisle of the church. After this person had returned from Burma after World War 2, he displayed this unusual behaviour, which was challenging to both his neighbourhood and the church he attended. This incident was one of many - the catechist could not allow the service to be interrupted in this manner so immediately and forcefully brought him down and held him on the floor of the church.

A possible explanation of his behaviour was demonic possession as it is not uncommon for Christian leaders in Ghana to explain extraordinary or strange behaviours as having a supernatural dimension (Liz, 2008). Simpson (2013) suggests there is a failure of Christian leaders and their congregations to understand congregants who are struggling with mental illness and the experience of their families, observing that some Christian leaders have said they could diagnose mental illness.

This story illustrates the response of some Christian leaders. In the review of the literature in Chapter 2 of this thesis various research and studies of the relationship between mental health, spirituality and religion, and Christian leaders caring for congregants struggling with mental issues, were identified. This was to determine gaps prevalent within the scope of this study, as well as how this research could contribute to addressing these gaps. Christian leaders' ministry to congregants with mental illness is often difficult as they are called upon to provide mental health pastoral care, and their response to such problems remains relatively unexamined (Leavey, Loewenthal & King, 2007).

This study is significant in its attempt to understand the problems Christian leaders face when caring for congregants with mental health issues and the type of training that will help mitigate these challenges. It was not my intention to generate a large amount of data, but to gain sufficient data that accessed the thoughts, mannerisms, feelings and experiences of my participants to enable me to understand the meaning they assigned to their experiences. As Christian leaders are often expected to be perfect, they do not talk about issues of 'pain' and 'failures' easily (Wilson & Hoffmann, 2007).

As a Christian leader, I was keen to bring together Christian ministers who were struggling to understand the mental health issues of congregation members, to offer them a mutually supportive safe environment and enable a trusting dialogue on the complexity of the problem. We could then explore our experiences and find solutions to issues of common interest. The participants' own experiences of the issues to be explored are important to the

study to enable them to develop knowledge of themselves and their training needs. The study aims to strengthen the literature on this subject and provide Christian leaders with an informed approach to the complexities of mental health care, a way of working with mental health that is distinctive to them. It was therefore important for the research design to use a methodology that provided a way to understand and explore in-depth the experiences of these Christian leaders, empowering them to express themselves openly to one another without restraint about their shared concerns and struggles in ministering to their congregants. In this regard, the researcher adopted a cooperative inquiry, sometimes referred to as collaborative inquiry, a research methodology developed by Heron and Reason (1997) for this research. This method uses participants who have similar concerns and interests as the researcher to understand, make sense of, and develop new and creative ways of looking at things to find out how to do things better. Heron (1996) emphasises that the methods are participatory, allowing the research to be with people and not on them. Those involved in the research are co-researchers, whose thoughts and decisions contribute to creating the ideas and co-subjects in participating in the research activity.

3:3 Research paradigms

> The application of any type of research method and the defence of the results of inquiry thus obtained implies a view, or views, of what is to count as knowledge. The point of preferring one set of methods over another is to believe that the chosen set will lead to knowledge rather than mere belief, opinion, or personal preference.
>
> (Bridges, 2017, p. 199, cited in McArdle, 2004).

As with many research studies, I had a choice in the methodology for this research. Creswell (2013) argues that no particular method has an advantage over others and the research question of the study should help determine the choice of the method, as different methods meet different needs. The primary questions for me were ‘how can Christian leaders address the mental health

needs of their congregants' and 'how can I use accurate data to generate new knowledge that identifies their training needs.'

I considered both quantitative and qualitative methodologies in order to decide which best suited the research purpose and answer the research question. As a mental health chaplain and a Christian leader, I believe that an in-depth exploration of Christian leaders' experiences would generate the data needed to understand the issues facing pastors and develop training needs to support congregants with mental health issues. My aim was to collect sufficient data of experiences, anticipation, fear, and anxiety by reflecting on vignettes produced by the participants. Knowledge would therefore come from a qualitative research method which would generate the rich data needed, rather than using qualitative methods such as surveys. These could for example involve 500 or more questions which would lead to producing a large amount of data and defeat the purpose of the study.

A qualitative approach to this research provides a framework to enable me to explore and understand the needs of the pastors (Munhall, 2012). According to Goulding (2002), a research methodology should be based on the researcher's convictions, beliefs, and interests. As such I needed to develop my role as a researcher and understand how it would impact on the research design and outcomes.

3:4 My background, beliefs, and biases

Riemer (1977) suggests that distinctive biographies, life experiences, and subject familiarity of a researcher could serve as an important source for research ideas and data. He argued that the researcher's familiarity with the subject matter helps to create rapport between the researcher and participants and contribute to more truthful data analysis. The sociologist Mills argues that sociological researchers have a responsibility to learn how to use their life experiences in their intellectual work. A researcher's craftsmanship is at the centre of his/herself, as they are personally involved in the intellectual product of the work (Mills, cited in Riemer, 1977, p. 468). Goffman (1989) argues that the researcher's identity is as much part of fieldwork as the worlds that

one studies, and the choice not to divulge the researcher's biographical background may prejudice the quality of the study.

My thinking about the world is largely informed by my religious calling, and professional mental health chaplaincy. I grew up in a culture where most believe in God and attend church, a culture where spiritual beliefs and the supernatural are part of everyday living. Beliefs and practices inform every facet of human life - African religion cannot be separated from everyday life (Chiorazzi & Olupona, 2015, p. 9). As a Christian, my understanding of reality was informed by my traditional heritage of the supernatural and the emergent Christian traditions (Chepkwony, 2005). My understanding of the world is based on biblical revelation, that there is a God who is actively involved in the world. He is both the transcendent and immanent expressed in biblical metaphor,

> Am I only a God nearby," declares the LORD, "and not a God far away? Can anyone hide in secret places so that I cannot see him?" declares the LORD. "Do not I fill heaven and earth?" declares the LORD. (Jeremiah, 23:23-24).

However, as a church pastor and mental health chaplain working in the NHS, I soon realised that pastoral care for congregants with mental health issues focussing on revelation and biblical explanations alone felt inadequate when addressing people's emotional, therapeutic, and spiritual needs (Kpobi & Swartz, 2018). Attempting to support congregants with mental health needs within a theological, religious, or cultural framework has been difficult in the light of the medical framework accepted as the norm in western culture (Stanford, 2008).

Both I and my congregants found it unhelpful when clergy relied on biblical text alone to guide relationships. As a chaplain working in a secular organisation, I became aware that competence in pastoral care involves interpretations from a range of disciplines and methods, including knowledge of mental health conditions as the traditional biblical interventions and answers had not always worked. Congregants found this helpful in making

sense of their experience, as it helped to co-create a new sense of meaning or normalisation of their experience.

I have an interpretivist understanding of the world, that reality is revealed to us by God. Truth and knowledge come through the interpretation of divine revelation as well as from my understanding, beliefs, perceptions, and experiences of how things work. I therefore approach this study with the understanding that knowledge and experiences are fallible, as they rely on human efforts to interpret and understand a phenomenon (Cohen, Manion, & Morrison, 2011). Qualitative research does not own a distinctive theory and paradigm but has a distinct set of methods or practices entirely its own (Denzin & Lincoln, cited in Ormston *et al.*, 2013). It is therefore important for me to clarify the particular ontological and epistemological assumptions that this thesis has adopted, and establish criteria to decide when the required knowledge for this study is both sufficient and genuine (Blaikie, 2009; Crotty, 1998); or adequate and legitimate (Maynard, 1994, p. 10, cited in Crotty, 1998, p. 8),

> the social world can be understood only from the standpoint of the individuals who are part of the ongoing action being investigated and that their model of a person is an autonomous one and understanding of individuals' interpretations of the world around them has to come from the inside, not the outside (Cohen, Manion & Morrison, 2011, p. 15).

There is a view that knowledge exists as meaningful entities, independently of consciousness and experience. These have truth and meaning residing in them as objects, and therefore careful scientific research can attain that objective truth and meaning. This is a positivist epistemology, which assumes that facts obtained from the scientific method can make legitimate knowledge claims. Here the researcher is separate from, and unaffected by, the outcomes of research (Creswell, 2014). So, sense-making and meaningful realities already reside in objects waiting to be discovered through employing quantitative methods (Crotty, 1998).

I take the view that knowledge is interpreted and constructed through human perceptions and interpretations (Bryman, 2008; Crotty, 1998),

> Kant argued that there are ways of knowing about the world other than direct observation and that people use these all the time. He proposed that perception relates not only to the senses but to human interpretations of what the senses tell us. As such, knowledge of the world is based on 'understanding', which arises from reflecting on what happens, not just from having had particular experiences. Knowing and knowledge, therefore, transcend basic empirical enquiry (Kant 1788, cited in Ritchie et al., 2013, p. 11).

The ontological and epistemological considerations for this study are both interpretivist - Bryman (1988), Holloway and Wheeler (2010), Lincoln and Guba (1985); and constructivist - Blaikie (2007), Crotty (1998). In this way a researcher constructs meanings and interpretations and produces knowledge by exploring and understanding the social world of participants, focusing on meanings and interpretations. Blaikie (2007) and Crotty (1998) argue that the research process is considered to be largely inductive, in the sense that interpretation is grounded in the data and reality is affected by the research process. Facts and values are not distinct, and objective value-free research is impossible. Some researchers however aim to be transparent about their assumptions and attempt to adopt a neutral position; others embrace subjectivity and become more personally engaged in the research (ibid, cited in Ritchie *et al.*, 2013, p. 12).

To obtain knowledge for the research my ontological/epistemological position will be interpretive constructivist. My goal is to understand the complex world of the lived experiences of my participants, and to understand one must interpret these (Schwandt, 2000). As a researcher, I believe that meanings are constructed and the interpretation offered is based on the participants, in the sense that data is interrogated to generate meaning or knowledge of the participants and not to test a theory. This makes me as researcher personally involved in the participants' experiences, and I cannot

be detached from the study. So, I take the interpretive and constructivist position to emphasise the mutually close relationship between the researcher (myself) and the researched (the participants), suggesting that knowledge from this research was grounded from the participants' reflection and interpretations of their experience. Participants' interpretations are critically essential in understanding the work between the Christian pastors, church, and congregants with mental health issues.

Reality is constructed through interactions between a researcher and the research subject, "reality is socially constructed" (Mertens, 2007, p. 12). This point of view is,

> that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of the interaction between human beings and their world, and developed and transmitted within an essentially social context (Crotty, 1998, p. 42).

The interpretive-constructivist paradigm was appropriate for the study because it invites participants' active participation to meet the study's aim. The study envisaged an action and reflection agenda that would transform the participants' lives, inform the church in which pastors serve, and the researcher's life. Christian leaders would understand how the structures of mental health system encourage or prevent them from exercising autonomy and freedom in caring for their congregants. Grundy argues, from an emancipatory action research position, that participants develop an understanding of illegitimate structural and interpersonal constraints that are preventing the exercise of their autonomy and freedom (Grundy, 1987, cited in Cohen, Manion & Morrison, 2011).

Constructing knowledge from the participants' multiple points of view through collaboration from the multiple realities (Guba & Lincoln, 1989), the implication of the participants' co-producer role raises issues of power and control. I will explore this in order to make explicit the process of how outcomes were negotiated.

3:5 Control and power issues within the research

The relationship between the researcher and participants in qualitative studies, particularly in relational dynamics and researcher vulnerability, are well-studied (Råheim *et al.,* 2016). According to Fontes (1998) researchers are entwined with personal and professional identities, and their identities are said to be multi-faceted. Much of the debate on researchers' membership roles in qualitative research is in the areas of observation, field research, and ethnography (Dwyer & Buckle, 2009). Dwyer and Buckle say,

> The researcher's membership in the group being studied is relevant to all approaches of qualitative methodology as the researcher plays such a direct and intimate role in both data collection and analysis. Whether the researcher is an insider, sharing the characteristics, role, or experience understudy with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher, including her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation (Dwyer & Buckle, 2009, p. 55).

The danger is that the researcher is seen to have a privileged position over the researched, creating an inherent power inequity between them, and raising ethical concerns about this inequity (Råheim *et al.,* 2016). As an outsider to the commonality shared by participants the personhood of the researcher, including his or her membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation (Dwyer & Buckle, 2009, p. 55). For the positivist, the outsider positioning was considered as the objective norm, while insider positioning was seen to be a potential bias that threatened the quality of the research (Merriam *et al.*, 2001).

However, in the light of the shared knowledge and experiences of the participants, a methodology that offers ease of access to the field or participants; that is pragmatic in building a relationship with participants; and that aids a responsible data collection process, is advantageous to the

researcher (Chavez, 2008, cited in Ross, 2017, p. 327). The insider position proposes that the closer we are to the subject influences and shapes our work (Reay, 1996).

As the researcher, I was therefore careful to ensure shared understanding of critical concepts and encouraged explicit discussions in order to make essential conversations safe and comfortable for all (Chavez, 2008). Francis and Archer (2005) warn that researchers from similar social positions as their respondents may conflate experiences, or distort responses, to fit their own experiences. Issues of power and control may arise when a researcher, such as myself, holds multiple roles - a partial co-researcher who is also the participants' course leader and professional mental health chaplain. Although I identify as an insider in relation to the pastoral identity or experience, according to Merriam *et al.* (2001) power differentials associated with class privilege and race may also significantly colour the research relationship and how data is gathered.

3:5:1 My insider position

In the context of this research, I will describe myself as an insider within my particular life trajectory - a person of colour, Baptist minister and professional mental health chaplain working in the NHS, a secular organisation. Angrosino (2007) suggests the importance of understanding the researcher's context, gender, class, and ethnicity as part of narrative interpretation. I feel conflicted regarding the nature of my role as a researcher, partial co-researcher and co-subject. Adler and Adler (1987) identified the 'membership roles' of qualitative researchers and this poses two interesting dilemmas for me (as the main researcher), and my co-researchers and co-subject participants.

My life's journey and my professional trajectory have placed me in various locations along the insider-outsider continuum. In the first group (identified as Southeast 1, as participants were all Caucasian) I wondered about what my participants thought of me as a Black researcher, and what I thought of them as White co-researchers. Torres and Charles (2004, p. 115) suggest "most Blacks seem to have internalized a piece of these negative stereotypes", the

experience and views of the racial attitudes that White people have of Black people, perceived through their own eyes. As the research initiator from the insider position, a sense of self-doubt was triggered by a sense of Black intellectual inadequacy, but this did not warrant spending considerable energy to debunk my feelings of intellectual inadequacy (Vass, 2015).

Although this racial complexity may be absent from the participant group, as the participants were all known to me and we had a cordial relationship before the study, I was aware of the need of proving myself. This internal struggle was managed by the complete membership ethos of participants; a good rapport between me as the initial researcher and my co-researchers. In addition, an inbuilt face-to-face value trust between me and the group members gave legitimacy to the relationship (Dwyer & Buckle, 2009).

As the researcher I was conversant with the language of the subject being studied and therefore able to reorganise questions to both help the group interrogate relevant issues and provide an accurate interpretation of their world more truthfully. My co-researchers were comfortable with a more robust interrogation of their data. Riemer (1977) has cautioned that if the researcher becomes too emotionally involved with the participants the result of the study may be biased by the researcher's aim. Researchers may struggle with role conflict if they find themselves caught between “loyalty tugs” and “behavioural claims” (Brannick & Coghlan, 2007, p. 70). Asselin (2003) has pointed out that a dual role can result in confusion when the researcher responds to the participants or analyses the data from a perspective other than that of the researcher. Asselin observed that role confusion can occur in any research study but noted a higher risk when the researcher is familiar with the research setting or participants through a role other than that of researcher (cited in Dwyer & Buckle, 2009).

Reason (2003), Srivastva, Obert and Neilson (1977, cited in Reason & Bradbury, 2008) suggest co-operative inquiry participant groups will need to deal openly with issues of inclusion, control and intimacy as the issues will need appropriate facilitation. According to Reason and Heron (1996) the

process of the interpersonal relationship among participants can enhance a researcher's facilitation skills to stimulate a fertile ground for communion and practices - meeting in a circle, sharing time equally, listening attentively and so on (for examples see Baldwin, 1996; Randall & Southgate, 1980, in Reason & Bradbury, 2008).

I will draw on McArdle's work with a group of graduate students and faculty at the University of Bath on the issues of power and participation (cited in Reason & Bradbury, 2008, p. 369). When this group began to discuss issues of power and participation the feeling of tension increased, and strong feelings were expressed. Holding and resolving the tension within the group involved listening to each person in turn, fully and without interruption, and recording their experience clearly in writing on the whiteboard. Eventually the participants became quieter, more appreciative, more deeply understanding of their differences and the shared pattern of experience. I reflect on how I managed the tensions that arose in our group in section 3:8:1b.

3:6 Cooperative Inquiry Methodology

According to Reason and Bradbury (2008) co-operative inquiry is a form of action research in which all participants work together in an inquiry group, as co-researchers and as co-subjects. It brings together people with similar encounters, i.e., professionals from the same discipline or field, with a focus on learning through conversation and collaboration (Reason, 1994). The purpose of my research was to bring Christian leaders together and through conversation construct knowledge related to the pastoral practice of dealing with congregants with mental health issues. The methodology proposes that everyone is engaged in the design and management of the inquiry; everyone enters into the experience and action that is being explored; everyone is involved in making sense and drawing conclusions. Thus, everyone involved can take initiative and exert influence on the process (Heron, 1996).

The proponents of the methodology argue that this is not research *on* people or *about* people, but research *with* people (Heron, 1996; Heron & Reason,

2001; Reason, 1998, 1999, 2003, 1988, 1994; Reason & Tolbert, 2001, cited in Reason & Bradbury, 2008). The cooperative inquiry methodology focuses on participants' experiences and ascribes meaning to the individual and collaborated experiences.

As discussed in section 3:6:1, cooperative inquiry proposes that you cannot examine the human condition from the outside but only from the inside (Heron, 1996). The human condition is an incarnate one, known only through insider knowledge. It is only in and through total embodiment in face-to-face interactions and relationships with others similarly embodied that you have insider access to what is being studied (Heron, 1996, pp. 200-203). Therefore, unless I made participants co-researchers, they may not be fully present and persuaded to the researcher's will (Heron, 1996).

According to Mason (2006), using a qualitative paradigm better explores the extensive understanding and deeper insight into complex human behaviours and issues. The participants bring together their various realities, based on subjective truths and experiences. Therefore,

> there is no single, objective reality, there are multiple realities based on subjective experience and circumstance (Wuest, 1995, p. 30, cited in MacDonald, 2012, p. 35).

I was attracted to cooperative inquiry because of its participatory nature, it aims to increase people's involvement in the construction and application of knowledge about themselves (Heron, 1996; Reason & Bradbury, 2008).

The Christian leaders did work together through the four phases of action explained in section 3:6:1 and develop their understanding and practice by engaging an extended epistemology of experiential, presentational, propositional and practical ways of knowing (Heron & Bradbury, 2008). Reason (1999) explains that extended epistemology articulates,

> the mutually enhancing effect between the four ways of knowing, rather than valuing propositional expressions over and above the other forms of knowing (Heron & Bradbury, 2008, p. 374).

3:6:1 The four phases of cooperative inquiry (extended epistemology)

According to Heron (1996) cooperative inquiry creates a research cycle among four different types of knowledge: propositional knowing (knowing something in intellectual terms); practical knowing (the knowledge that comes from an action or the practice of your proposition); experiential knowing (the knowledge of being present, the face-to-face encounter with people and place); and presentational knowing (the knowledge that arises from the encounters of experiential knowing). These forms of knowing are what Heron (1996, p. 52) refers to as "extended epistemology" - a theory of how we know, extended beyond the ways of knowing, principally the theoretical and propositional knowledge accepted within academia.

Epistemology in cooperative inquiry is held within the four subjective forms of knowing mentioned in section 3:6. It begins during the participative relationship of participants, with knowledge generated through the relationship and in inquiry practice with others. These are described in section 3:6:1.1.

3:6:1.1 Experiential knowing

This is knowing through presence, the direct face-to-face encounter with participants or the topic under study, the experience of my presence with the presence of participants (Heron, 1996). Heron and Reason (2008) suggest any form of inquiry that fails to honour the experiential presence ignores the fundamental grounding of all-knowing. A study by Mead, grounded in experiential knowing, suggests that action research remains as speculative and "theoretical" as its reductionist cousins, if it is not confirmed in the experience of participants (Mead, 2001, p. 66, cited in Heron & Reason, 2008).

This research study is fundamentally exploratory, rooted in a participatory worldview. Thus, to experience anything is to participate in it. Participatory can be described as 'declarative' and the qualitative impact declares the tangible sense of the realness of the presence of each to each, and each to herself or himself, all of this in a shared field (Heron & Reason, 2008). The

Christian leaders in the cooperative inquiry meeting were open to (and appreciated the quality of) this shared field. Therefore, the quality of the field, whether enjoyable or chaotic or shattered, is a living key to appropriate understanding and action in the situation and a vital component of our experience of interpersonal reality (Heron & Reason, 2008).

Experiential knowing is feeling engaged with what there is, participating through the perceptual process in the shared presence of mutual encounter (Heron, 1998). An implication for experiential knowing in the reflection phase is when the co-inquirers feel present, open to the encounter and with themselves. The success of the group is determined when the co-inquirers develop and live a sense of pre-conceptual communion or resonance in their shared life-world, as grounds for subsequent reflection together (Heron & Reason, 2008).

3:6:1.2 Presentational knowing

Presentational knowing is when images are used to articulate experiential knowing, bringing to light the communicable form through nondiscursive visual arts, music, dance, and role play for participants to tell their stories. Presentational knowing is a fundamental process of cooperative inquiry, it expresses a meaningful outcome in its own right and acts as an important forerunner to propositional outcomes. For my Christian leaders, presentational knowing in the reflection phases of inquiry provided a sense of pre-conceptual communion or resonance in their shared world of mental health care as a ground for subsequent reflection together. The arrangement of facilities, the mutual participation and openness emphasise equality and mutuality of participants. All the participants for this study sat together around joined tables, symbolising the fundamental qualities of our relationship.

Heron (1996) narrates how presentational knowing creates harmony in common resonance, postures, gesture, and spatial interaction, opening an empowering presence between co-inquirers. This gave the imaginal space and allowed sense-making magic, allowing our stories to resonate with

participants in the group (Mead, 2001; Reason & Hawkins, 1988, cited in Heron & Reason, 2008). McArdle, in her co-operative inquiry of young women in management, alluded to the importance of storytelling as a lead-in to the propositional for her participants (McArdle, 2004).

The Christian leaders created vignettes of their stories which we then interrogated to create shared meaning and understanding around mental health care in our churches. Having stories as the feature of this inquiry allowed participants to explore, explain, express, analyse and understand a new important dimension of their work. Heron (1981) cited in Reason (1988) suggests that knowing expressed in art, in poetry, dance and in telling of stories falls in the realm of presentational knowing. So, for my participants expression was the method of making sense of their experience. It was their deep participation that gave meaning to their experiences when a participant shared a story.

3:6:1.3 Propositional knowing

This form is knowing that comes from the use of ideas and theories to communicate the facts of issues in order to make sense. According to Heron (1996) propositional knowledge is ‘about' something expressed in statements and theories to provide insight into social relations, and to offer propositions and theories that will aid the understanding of the collective relation. Propositional knowing places emphasis on the research cycling process to allow propositions to be tested in practice. Concepts are not left to spread like wildfire in the mind of participants but become grounded in the experience of the participative relationship and its statements, coherent with its participative knowing.

The propositional sense-making of the group was important in giving the repeated process, communicating clarity of learning from the previous action cycle to the next. For example, one inquiry group exploring the implementation of child protection guidelines describes how the propositional knowing re-energised a tired process and gave clarity to the group (Charles & Glennie, 2002).

3:6:1.4 Practical knowing

Heron (1996) asserts that practical knowing is the knowing of 'how to' do something expressed in a skill, or competence. This is evident in the skills and competencies the inquirers develop, both in knowing how to implement co-operative inquiry and how to apply those transformative actions in the world with which the inquiry is engaged (Heron & Reason, 2008). Participants develop personal skills of awareness, openness and abilities associated with opening an inquiring space for others.

I shall outline the evidence of how extended epistemology informs our practice in Chapter 5 of this thesis. The above is a process of how cooperative inquiry generates knowledge, for example inviting the participants to decide on issues and communicate to each person what is agreed which in turn helps to open up discussion. For example, in the roleplay of a vignette the acting was an important outcome – it opened up new conversations grounded in experience and enabled us to continually locate ourselves in interesting questions about what we had done, what we might do better, and what we might do next (McArdle, 2004). In the session explaining the action and reflection cycles, I will outline how vignettes were understood and used. Record-keeping and how results were captured was a feature of the action phase because of how the reports were presented - for example accounts that involved a drama presentation or drawings led into the subsequent reflection phase.

The concept of extended epistemology in the cooperative inquiry methodology has validity implications. Validity is expressed in the cycle of congruence existing between the four phases. The knowing is grounded in experience, expressed through our images and stories, understood through ideas and notions from our cognition and completed through worthwhile action in our lives. This process enriches the validity of knowing and enriches the lives of my participants rather than only a concept they should know about.

There is some caution that may threaten the validity of this process. Heron (1996) suggests it is possible for experiential knowing to be trapped in illusion, making it impossible to generate new knowledge. Presentational knowing may repeat what is already known, to create and confirm existing realities. The potential fault in propositional knowing is to remain too trusting, which hinders the criticality of ideas and theories. The potential issue in practical knowing is the tendency of not testing practices against outcomes (Reason, 2003).

3:6:1.5 Forms of co-operative inquiry

Heron (1996) suggests co-operative inquiry can take many different forms depending on the nature of the inquiry. Any proposed research can use a cooperative inquiry method suitable for the study. An inquiry may be initiated by either one or more researchers wanting to use the method, who then invite others to join them to focus their investigation. The initiators may be internal to the investigation which makes the initiators both fully co-researchers and co-subjects. Other initiators may be external to the inquiry topic or investigation, so cannot fully be co-subjects. My investigation with the Christian leaders is an example of externally initiated investigation. In others, inquirers may form a same-role investigation. For example, they may all be doctors, or they may form a 'counter partial role inquiry' where the inquiry explores the practitioner-client relationship. The inquiry group may be composed of doctors and patients, or the inquiry or investigation may be mixed-role, which includes different kinds of practitioners exploring differences and similarities in their modalities of practice (Heron, 1996, pp. 42-34).

The inquiry was organised around four phases of action and reflection cycles, as the co-operative inquiry process is iterative cycling between phases of action and reflection (Heron, 1996; Reason, 1994; Reason & Heron, 1999, cited in Oates, 2002). The choice of where the action phase is focused is determined by the subject of the inquiry. With inside inquiries, all actions occur within the same place within the inquiry group. The whole action

phases in inside inquiries include the whole inquiry group exploring the nature of that group (McArdle, 2004). An outside inquiry however is concerned with working projects outside the meeting group, so the group comes together for reflection to share their data, make sense of issues, and revise their thinking (Heron, 1996). So, the action phases occur outside group meetings and reflection phases occur together.

It is worth noting here whether the boundary guiding the inquiry was open or closed. An open inquiry includes interaction between the inquirers and others in their wider world, whereas closed inquiries are concerned solely with interactions within and between the participants' inquiry group. Here the inquiry is concerned entirely with what is going on between researchers and the participants and does not include as part of the inquiry live interaction between the researchers and others in the wider world (McArdle, 2004). The choice of a closed inquiry group will be addressed in section 3:8:1.

3:6:1.5a Cycle 1 (a reflection phase)

In this phase, the group of co-researchers met for the first time to explore and agree on how to proceed with the study. At this first meeting we agreed to develop a set of questions and propositions and decided which actions were needed for exploration. We also decided on a method for recording experiences in the reflection phase, and a procedure to review them during the cycling process (Heron, 1996; McArdle, 2004; Oates, 2002).

3:6:1.5b Cycle 2 (an action phase)

In Phase 2 the group applied the agreed actions from Phase 1. We initiated the actions and observed and recorded the outcomes of our own and each other's behaviour. In the second cycle personal practice became the focus. The co-researchers became co-subjects, carrying out the agreed actions, observing and recording the process and outcomes of our own and each other's actions and experiences. Participants immersed themselves in the issues to give a better understanding of the experience and tried out new forms of action to gain new knowledge and insight.

3:6:1.5c Cycle 3 (an action phase)

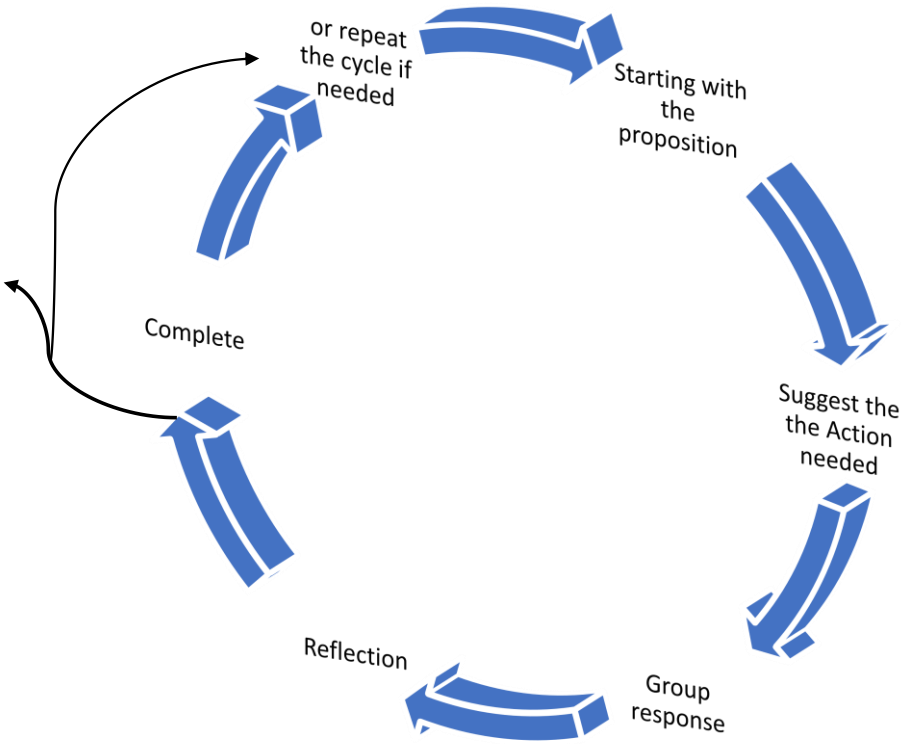
In Phase 3 the co-subjects become fully immersed in and engaged with their experience. Participants developed new insights, leading into new fields, unpredicted action, and creative insights. They became so involved that they lost awareness of being part of an inquiry group and metaphorically 'fell asleep', reverting to ordinary rather than heightened consciousness (Oates, 2002).

3:6:1.5d Cycle 4 (a reflection phase)

In Phase 4, after the agreed period of meetings in Phases 2 and 3, the co-researchers met again to re-consider their original questions and propositions in the light of their experiences (Oates, 2002). At this stage, the co-researchers may modify, develop or reframe the questions of proposition and pose new ones for the next cycle of action and reflection (Heron, 1996).

Figure 1: The Co-operative Inquiry Method

The diagram suggests the distinctive characteristic of the cycles of the cooperative inquiry method with the following phases: the proposition, the suggested actions as agreed by participants (vignettes), the debate and responses (checking and suitability), and reflections (moving forward with the model). The cooperative inquiry research spiral figure is taken from Alexander (1998),



3:7:2 Presenting cooperative inquiry as a thesis project

My thesis seeks to embrace methods of cooperative inquiry and show how it was used for this study. The readings referenced in this chapter gave me a useful introduction to the ideas embedded in the methodology and I will demonstrate how the participants, in the practice of it, made it their own to suit the purpose of my research.

Personally, co-operative inquiry as a method resonates with my beliefs about how people learn and generate knowledge. I enjoy a research approach or approaches that empower participants to work together to examine their lived experiences, make sense of it, to enable change and improve their lives (Reason, 1988). Politically, the methodology was suitable for participants whose voices may be silenced by mental health professionals, and who possibly felt disempowered, oppressed, and misrepresented by those values

that they perceive to be implicit in any unilateral research design (Heron, 1996, p. 21).

From a perspective that focuses on collaboration, the methods of cooperative inquiry offered me a way of engaging with pastors to find their voice and learn about them through their stories. In addition to the above, Heron and Reason (2001) suggest this method did not require me to be an 'expert' before I could use it for my study. It was presented as being available to inexperienced people, who wanted to conduct an inquiry to transform everyday lives (Heron & Reason, 2001). According to Reason (1988) it is the researching *with* people, rather than *on* people that made sense to me. The co-operative inquiry methodology has been applied in many diverse fields, such as studies looking into altered states of consciousness, Black managers and subordinates, child protection supervision, co-counselling, co-operation between conventional and complementary practitioners (Reason, 1999), dental practitioners, district council organizational culture, health visitors, obese and post-obese women, other people with a particular physical or medical condition taking charge of how their condition is defined and treated, whole-person medicine in general practice (Heron & Reason, 1985; Reason, 1988), women staff in a university, young women managers, youth workers, and so on (Heron, 1996; Reason, 1988, 1994).

The methodology has been adopted and used in other doctorate projects, for example "Constructing a research strategy in a university nursing department: a cooperative inquiry" (Whitney-Cooper, 2011). The postgraduate academic framework for a doctorate in education handbook embraces a capacity for a rigorous investigation informed by theory and practice (CCCU, 2013, 2019). It is therefore important for me to show how my professional experience is evident and transparent in the thesis. Reason suggests writing in the first person to show that the researcher is an integral part of the interpretation of any research because, in the co-operative inquiry, the role of the researcher could be obscured by the dual identity as co-researcher and co-subject (Reason, 1998). So, it was epistemologically inconsistent to write a report that did not identify me as the author (Lincoln & Denzin, 2000).

Writing the report narrative in the third person will obscure my role as a researcher (McNiff, 2008). Using the first person will clarify my integral role in the doctoral report to make explicit my subjective position and influences (Reason, 1998). It adds to the subjective experience as part of the evidence for the author's claims and makes the author's perspective and constructive role in creating meaning in the study more visible (Zhou & Hall, 2016). Kamler suggests that elements of qualitative research include the words of the author and participants that constitute the actual evidence in the study (Kamler, 2001, cited in Zhou & Hall, 2016).

Heron (1996) suggests cooperative inquiry can be internally or externally initiated. Internal initiators are personally engaged with the culture or practice which the research is about, making them full co-subjects; while externally initiating researchers are external to the particular culture, so cannot be full co- subjects. I am the initiator of this study and, once my role of initiating and education participants is over, may continue in a lesser position as a co-researcher. My role as a partial co-subject gives me a reduced warrant to contribute relevant data to the description and explanation at the reflection phase.

From the onset, the participants were made aware of my role as the initiator and how my co-subject involvement was therefore reduced. This will be noticeable as I make substantive prompts and reminders about the key aspects of the inquiry method (Reason, 1994, cited in Heron, 1996, p. 201). Although not full co-subjects, a common interest in developing our inquiry skills and practice enables us to remain engaged. In light of the above discussion, the cooperative inquiry methodology was amended to suit my doctoral study.

3:7:2.1 Amending and adapting the cooperative inquiry approach

This section explains why the researcher adopted a partial cooperative inquiry approach (Heron, 1996). The researcher positioned himself in the inquiry to respect the autonomy of the participants and to work with the group in balancing discussions to achieve a democratic equilibrium needed for the group. Participants would therefore not be marginalised or in any way

silenced, needed in order for the group to build mutual respect and common purpose (Reason & Bradbury, 2008). Such independence from the researcher's interference gave the participants a chance to recognise and express preferences for a democratic or political decision to emerge, reflecting the researcher's values in the design of the research (Heron, 1996). For example, the participants had the choice of using vignettes; or to perform an action with a congregant. From the outset, the participants chose to reflect using vignettes from their own stories and reflecting on that at the inquiry meeting. Heron states that,

> …cooperative inquiry in its fullest form, any distinction between the researcher and subject disappears because all participants are both co-researchers and co-subjects (Heron, 1996, pp. 19-21).

Full cooperative inquiry for the study was not possible for the reasons given in 3:7:2. As co-subject, my involvement was to act as an external educator to the inquiry group and participate in the research reflections on peer basis throughout the inquiry. I amended and opted to use the partial form of co-operative inquiry to suit the doctoral requirement of my study, so the researcher can show his contribution to knowledge through original and independent investigation. Therefore, the cooperative inquiry with participants had to be initiated externally to suit the doctoral academic requirement, this will enable me to be a partial co-subject with my Christian leaders as co-researchers and develop a joint working relationship.

3:7:2.2 Partial form of cooperative inquiry and the issue of tension

Given my interest in how Christian leaders look after the mental health of the congregants, the question was how to involve participants fully as co-researchers and co- subjects. As the initiator - the person who identified the problem to be explored – for me, the challenge was to set up a participant group who could work co-operatively, given that the original ideas for content and process were owned by me. This presented the possibility of tension between me and the group. These tensions were unavoidable as the research

was initiated externally by me, with needs or objectives which might not fully correspond with those of the other participants wanting to pursue a different line of interest. So, it was important at the outset to explore the aim of the study and to reiterate that it was a doctoral project.

These transparent discussions with my participants contributed to a genuine cooperative inquiry endeavour (Heron, 1996). The cooperative inquiry group talked about what the research is for, right of ownership and whether it could be a genuine collaboration (Reason, 1988). Reason further suggests that an inquiry task that genuinely explores challenges relating to initiation, ownership and power can resolve those issues through authentic negotiation and confrontation. Not dealing with these negotiations places the possibility of genuine co-operation at risk (ibid, p. 21).

As the research initiator, I selected potential participants from the field to be explored, to ensure that any differences in power and status did not make it impossible to negotiate an open, transparent, and unequivocal contract (Reason, 1988). However, I could invite an external person to probe these challenges if needed (ibid).

I dealt with these challenges using a facilitation group skillset gained from running a spirituality support group, and knowledge from facilitating a professional development group. The 'partial form cooperative inquiry' (Heron, 1996) is summarised in Table 1 below:

Table 1

Grid taken from Heron (1996, p. 23) explaining the partial form of cooperative inquiry

	Researcher	Subject
Participation in decisions (political or democratic). Political participation involvement in research thinking and decision making	Full	Full
Participation in experience (epistemic) Epistemic participation involvement in experience and action being researched	Partial	Full

3:8 Participants

For this study, I wanted participants who were experienced in pastoral care including mental health, with reasonable competence to be aware of their experiences and reflect on them both in words and concepts. I therefore selected Christian leaders who had attended my Introduction to Mental Health Issues in Spiritual and Pastoral Care course (Appendix 2); as they had some knowledge and understanding of mental health issues and practice with their congregants. I believed such a participant base would supply ideas to real situations that would enrich my data.

I sent out two letters. The first was an open invitation intended to recruit research participants. From the 30 letters sent in July 2016, four people from Southeast 1 showed interest. Due to these low numbers, I broadened the participant recruitment to include Southeast 2 and following the same recruitment process eleven more participants enrolled for the study (Appendix 3).

A second letter outlining the research process and expectations were sent to the would-be participants (Appendix 4). In response to my invitation, 15 people joined (including myself). I therefore formed two participant groups, Southeast 1 and Southeast 2, with all members having participated and completed a programme in mental health issues in spiritual and pastoral care.

Participants from Southeast 1 had completed the whole course (Appendix 2), whereas in Southeast 2 the participants were from a group where I had taught three modules of their mental health course - spirituality and models of recovery; the interface between spirituality, religion and mental health; and a dimension of the spiritual view in mental health drawn from 'transpersonal psychology' (Friedman & Hartelius, 2015).

The participants were all Christian leaders from different denominations including church ministers, pastoral workers, and mental health advisors. The two training programmes provided me with participants who had the knowledge and awareness of mental health issues within their communities and the relevant skills to reflect on practice to help with my study. The participants met in two different locations (referred to in the thesis as Southeast 1 and Southeast 2).

The cooperative inquiry meetings shaped the overall strategy, provided a blueprint of the study, and discussed the approach taken by the researcher to conduct and analyse the research. The design chosen is "a partial form of cooperative inquiry" developed by Heron (1996) to provide specific direction in the research design (Creswell, 2007). Data collection was based on the action and reflection of the 15 participants from the two cooperative inquiry groups. The information about the participants is attached as Appendix 6.

3:8:1 Starting the inquiry and contract

In keeping with the research plan, the introductory session for the two groups was held on 7th December 2016 and 17th January 2017 respectively, each lasting two hours. At these meetings, I presented my research aims and the methodology, and clarified the selection criteria to the potential participants. Heron (1996, pp. 62-63) recommends that the initial cooperative inquiry meeting consider three interrelated suggestions to enable participants to make the inquiry meaningful, develop a joint decision-making process, and create an open sharing environment for true collaboration to take place. The three interrelated suggestions are:

- To induct would-be participants into the method of cooperative inquiry so we can make it our own.
- To talk about joint decision-making and how to achieve true cooperation.
- To enable an open and sharing climate for collaboration to take place.

I set this out here to present readers with the complexity of developing a coherent working group within the context of cooperative inquiry (McArdle, 2004). As the participants were not familiar with my methodology, it was important at this initial meeting for the participants to understand the method, and to realise the commitment. This initial meeting was presented as a small workshop which proceeded as follows.

I welcomed would-be participants to ensure they were made to feel at home. We started by talking about where they came from and their journey as a form of icebreaker. To create a more conducive environment I provided participants with beverages and invited them to talk about their interest in my study, their fears and expectations, and also my concerns about how the study would develop. I was also able to clarify any ambiguity that my role raised for the participants. I asked the participants to work in pairs, talk and listen to each other with equal time for each person about their interests in my study. I moved around each group to listen, and to get potential participants talking in front of me. A summary of the discussions about why the participants wanted to be part of this research is included in the biographical data in Appendix 6.

I followed the guidelines outlined by Reason and Heron (1996) and Reason (1988) (see Appendix 8). I explained the purpose of the study and what was expected of the participants and suggested how the group might proceed, and explained the cooperative inquiry methodology (as outlined in section 3:6). Reason (1994) suggests that developing an ambience and identifying group values are needed in establishing a potential learning group. McArdle (2004) stated that her experience shows that it is not possible to set up such a group unless facilitators work to establish the conditions from which collaborative

inquiry can reasonably develop. It is when participants are happy and in agreement with the working values that they join the inquiry group (Reason, 1994; Heron & Reason, 1997).

Therefore, nothing was hidden, with the honesty of all participants and a visible inquiry process the cooperative inquiry group worked towards establishing its values, working principles and the defined roles needed to provide the basis for authentic collaboration (Heron, 1996). This introductory conversation led to a discussion of the practical details of how the group would work, particularly issues around choosing to join, how much time would be involved, and the commitment needed from participants to make it happen. It also addressed any anxiety issues of participants, such as the level of creativity needed (Reason, 1988). We agreed to support each other, ensure that no one person would take over the group and meet for three hours for a further three days.

I asked participants to show by hand if they had enough information to help with my study - one participant from the Southeast 1 group felt he did not have the experience necessary to make him a useful member, so declined to take part. Following the same process for both groups, participants confirmed their commitment to the guiding rules and consented to take part in the study by signing the consent form (Appendix 5). A summary of the decisions taken is included in Appendix 9.

3:8:1a Roles and decisions

I clarified the research purpose to help the group, to define how we work together, facilitate, bring the group back to the discussion when deviating, foster a sense of group cohesion and agree on dates for the next three actions and reflection co-operative inquiry cycles. The researcher (initiator) owns the report and does the analysis given that this study is for a doctorate. The participants agreed and decided that the research initiator has the sole responsibility of presenting the thesis as his single work. The researcher would bring back to the group the final analysis for checking and scrutiny.

From the beginning of this study, as both researcher and a partial co-researcher in the group, I positioned myself as working within the context of cooperative inquiry methodology, solely to do the analysis and write the report. Reason stated that reports and propositional representations of a cooperative inquiry "themselves need to be cooperatively produced or subjected to systematic cooperative editing and revision" (Heron, 1996, p. 101). In other cooperative inquiry reports, the initiating researcher is the sole author of the first draft and makes subsequent redrafts in the light of feedback from participants (Heron & Reason, 1981, cited in Heron, 1996). Heron (1996) suggests there is no one proper way of reporting a cooperative inquiry, and it would be wrong to support a single way of reporting. The participants agreed that the findings of the study were to be presented and discussed with the inquiry group and any corrections and feedback added to the final draft (Heron & Reason, 1981, cited in Heron, 1996). Reason (1998) considers an inquiry which is part of a doctoral thesis to be situated differently, because of the challenge posed by the ideological clash between the normative University requirement for the research to be the candidate's original work and the ideas of the cooperative paradigm as discussed in section 3:7:2. As the study is for a doctorate, writing up a doctoral report is not a whole group exercise, it would be unrealistic to submit findings put together by the participants (Whitney-Cooper, 2011). The tension of sole authorship was managed by participants agreeing for the researching student to be the 'primary researcher', writing the views of the project in some form of consultation with members of the group (Reason, 1998, pp. 38-9).

Participants agreed that the researcher should feedback the findings from the group summaries to consider whether the findings were true for them. One participant was chosen to write agreed summaries of discussion on a flip-chart. My role of facilitation included organising the meetings, facilitating discussion, and playing a role as 'devil's advocate'. This did not mean that I had an exclusive leadership role, the group was rather participative and democratic. There was a consensus to audio-record the sessions, and I was given the sole responsibility for these recordings. All members agreed to be

present to encourage a high level of commitment - except for two occasions the sessions were fully attended.

Each Christian leader in the group had different roles within their churches and different theological positions on mental health issues. All had completed the mental health introduction course (Appendix 2), so in this sense, the inquiry group had the same aim of better caring for congregants with mental health issues, with a group sense of the co-subjectivity between them (McArdle, 2004). Because the research is about the mental health training needs of Christian leaders, theological discussions were relaxed in the group. The group agreed that any religious issues that arose would be contained and respected, as theological differences are a source of potential conflict that would disrupt the dynamic flow of the group.

This position allowed participants to share theological and religious opinions about mental health. The group was to focus on theological questions about their struggles from the vignettes, as this raises issues rather than delivering answers. However, if a group member felt strongly about theological issues, each group member was to offer their opinion as to theology that had helped to provide a model for how we deal with mental health. In this way, both the group and the research benefitted from examples of what had worked and identified theological struggles.

This was a closed boundary cooperative inquiry, where the Christian leaders explored experiences of caring for congregants with mental health issues. For action, the Christian leaders agreed to use stories of their past encounters with congregants. Vignettes - true stories told by the Christian leaders about their experiences in pastoral and supporting congregants with mental health issues - were brought to the inquiry group. The congregants were not members of the inquiry group and had no say in how the stories about interactions with them were told, as the investigation was about the Christian leaders. The inquiry action was writing the vignettes from individual experiences so participants could learn about "how we see what we see" (McArdle, 2004, p.

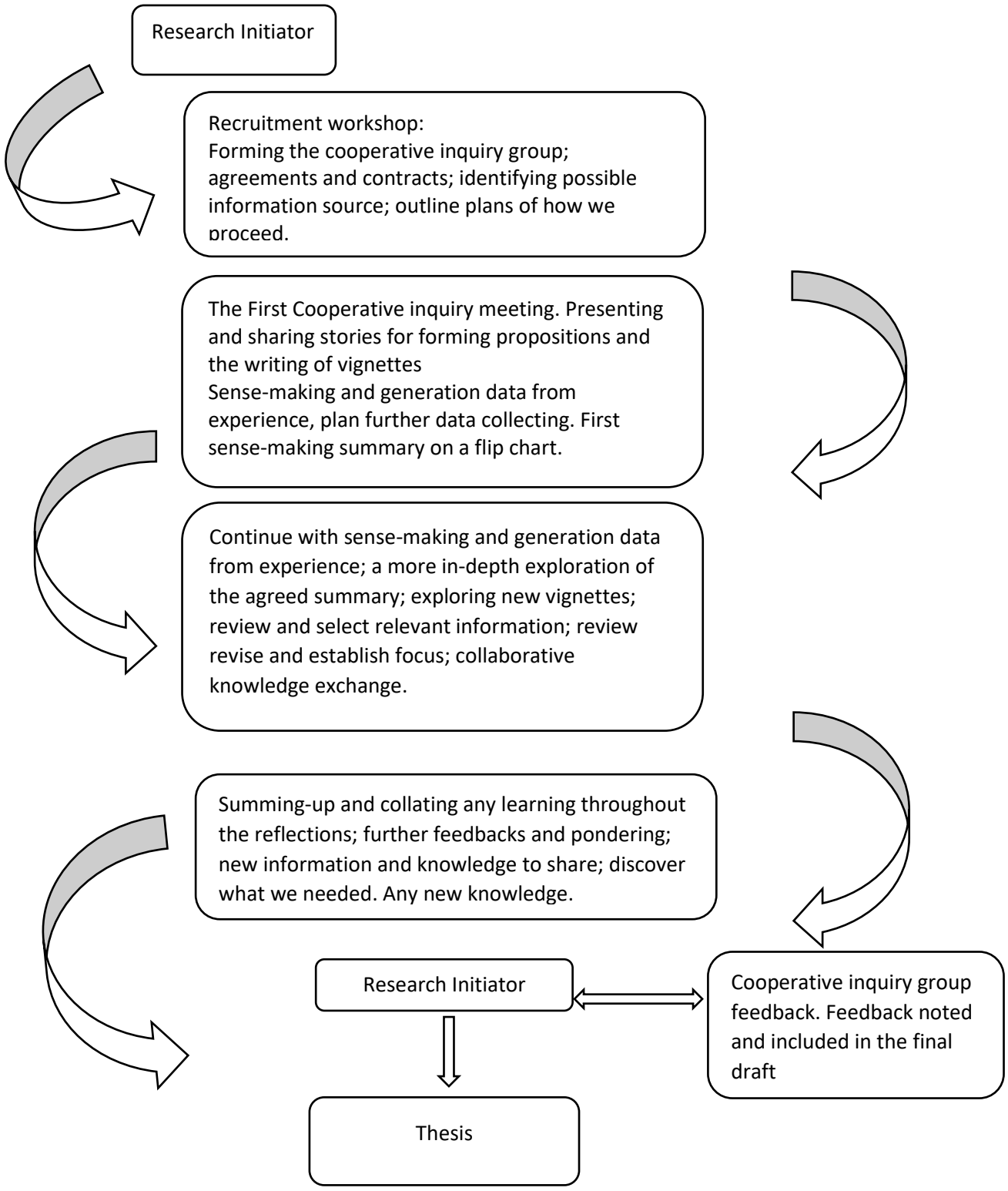
67). So, the vignettes (Appendix 10) looked at were from the participants' real experience and for me, it was these that helped each other to investigate into and understand our practice.

Hill (1997, p. 177), Hazel (1995, p. 2) and Hughes (1998, p. 381, cited in Barter & Renold, 1999) describe vignettes as reports about individuals, situations and structures which can refer to important points in the study of perceptions, beliefs and attitudes. According to Barter and Renold (1999) researchers have constructed their vignettes around actual experiences, either directly (for example by using situations provided by participants in the pilot stage of the research) or indirectly (such as using agony aunt letters in teenage magazines) (Harden, 1999, cited in Barter & Renold, 1999). Meyer (1993, cited in Spalding, 2004) argued in research with health care professionals that vignettes can represent real-life events and be a means to reflect on practice as a vital step in the action research. Hughes and Huby (2002), in their study on the advantages and drawbacks of using vignettes to prompt research interview questions, suggest vignettes used alone or in conjunction with other research techniques can be valuable research tools in the study of people's lives, their attitudes, perceptions and beliefs (ibid, cited in Spalding, 2004, p. 388).

The vignettes and stories of participants' experiences of congregants were examined to inform the research. The cycles were focused on the vignettes (action) and discussion (reflection) - for example participants observed a role-play of a vignette and then there was a general reflection. However, this is not the case for all the vignettes.

Figure 2.

This explains the cycles of reflections and activity at the cooperative inquiry group. Adapted from Reason (1988, p. 202):


Research Initiator
Recruitment workshop:
Forming the cooperative inquiry group; agreements and contracts; identifying possible information source; outline plans of how we proceed.
The First Cooperative inquiry meeting. Presenting and sharing stories for forming propositions and the writing of vignettes
Sense-making and generation data from experience, plan further data collecting. First sense-making summary on a flip chart.
Continue with sense-making and generation data from experience; a more in-depth exploration of the agreed summary; exploring new vignettes; review and select relevant information; review revise and establish focus; collaborative knowledge exchange.
Summing-up and collating any learning throughout the reflections; further feedbacks and pondering; new information and knowledge to share; discover what we needed. Any new knowledge.
Research Initiator
Cooperative inquiry group feedback. Feedback noted and included in the final draft
Thesis

3:8:1b Managing Tensions:

In section 3:7:2 I discussed some of the challenges and tensions I encountered using the cooperative inquiry methodology for a doctoral study, particularly in the writing of the report to meet the requirements for a doctoral award. This section further outlines how these tensions and challenges were considered and resolved. My participants asked about what was in it for them, how would the report be authored and whether would they get a copy of the final report? My initial response was it is my doctoral work, and I needed the data to analyse. Therefore, it is my work and not work for the whole group, forgetting that in cooperative inquiry this would have to be carefully managed. I explained to my participants that it was important for me to show my 'independence' and 'distinctive voice' at a doctoral-level study (Dunleavy, 2003). I have considered how the issue of authorship of the report was managed under roles and decisions in 3:8:1a.

According to Bravo-Moreno (2003) and Whitmore (1994, cited in Karnieli-Miller, Strier & Pessach, 2008) information and initial decisions regarding the control of the research process is at the discretion of the researcher. As the initiator of the research, it was important to get the balance between the researcher's independence and the autonomy of participants. The aim at this stage was to persuade potential participants to participate in the research and share their personal experience and knowledge. As the researcher (who owns the information about the study), and the participants (who own the knowledge and experience needed for the study), both participants and I commanded respective powers to negotiate the level of information provided. As research initiator and in my role as facilitator of the recruitment phase, there is the very real possibility of using power to influence, persuade people to become participants to make up my numbers when the decision is theirs to make.

To manage this form of coercing, I first tried negotiation to give participants more information and clarity on the research goals. Secondly, I respected the autonomy of my participants, which gave them greater power and control over how their information was used to meet the objective of the study. This

was achieved through recruiting early, to give myself and participants time to think through the project and make an informed decision and maintaining an open structure in collaboration with participants. Karnieli-Miller, Strier and Pessach (2008) suggest open and transparent negotiation between the researcher and participants has the potential to change the power relations between them. The ongoing rapport between participants and I was necessary to achieve understanding and empathy, which was likely to increase participation and produce rich research data (Karnieli-Miller, Strier & Pessach, 2008). Not only was I dependent on participants' willingness to share their knowledge and experience, but they also controlled and owned the data. It was therefore important for the participants to agree on what data was to be used, to reduce the risk of participants' distress particularly among those who may be vulnerable during the study (Krayer, 2003, cited in Karnieli-Miller, Strier, & Pessach, 2008, p. 283).

As the data collected was based on consensus, through the democratic nature of participation the risk of collecting data participants did not want to share was minimised. The possibility of me taking control of the research process was reduced by the active participation of the co-researchers and the level of cooperation in the discussion. However, with the end of the data collection stage, formal control and power over the data interpretation and analysis returned to me.

Another consideration to overcome any power imbalance between my co-researchers and I was to include myself in the discussions - allowing participants to give me feedback on the analysis made the inquiry cooperative rather than one-sided.

Ethical consideration pertaining to conflicts and power issues are discussed in session 3:8:2.

3:8:2 Ethical consideration

The research proposal was subjected to internal review by the University's Faculty of Education ethics review committee, which granted approval for the study to commence (Appendix 1). The process of cooperative inquiry

raised ethical questions about the vulnerabilities of all involved in the research, so it was vital that participants felt safe and protected, directly or indirectly, from any immediate and future harm because of this study. Tolich argues that the "vulnerability of people involved is much more than an informed consent procedure" (Tolich, 2010, cited in Groot *et al.,* 2018, p. 6). This brief section details the steps taken to ensure proper ethical considerations were adhered to in the eleven hours (over four days) of group work together. During the inquiry cycles, I anticipated the following possible ethical issues and responded to them in several concrete ways:

(1) a stress on privacy, confidentiality, and anonymity

(2) managing disclosures and acknowledged vulnerabilities and power differences

(3) an emphasis on the duty of care to participants

(4) how roles were negotiated

(5) the issue of ownership

3:8:2.1 Informed Consent

One participant, Angelina, was concerned about issues of confidentiality and anonymity. Another, Emilia, talked about the safety of information shared in the group, and wanted assurance that the content of our discussion was not divulged outside it. This issue was fully discussed, and we mutually agreed how to maintain confidentiality in the group. Participants agreed to adhere to 'Chatham House Rules', allowing participants to use information received freely but without revealing the identity nor affiliation of the speaker(s), nor that of any other participant (Chatham House, 2018).

Although they had consented to participate in the research, participants could leave the inquiry group at any time if they did not wish to continue. I assured all participants of full anonymity and that pseudo-names would be used to protect privacy and obscure real identity - all names in the research study were therefore anonymised. The audio recording was password protected and will

be destroyed following the university confidentiality protocols (Code of Conduct: Practice for Research Involving Human Participants and Animals, 2018).

To ensure that the storage of tapes and transcripts was secure all identifying details were altered so that the identification of participants was not possible through a process of elimination. I thought of consent as a process instead of a one-time agreement, to allow us to pause and reflect on autonomy and to reaffirm our commitment. During our reflections, as participants disclosed more personal issues, we revisited the issue of consent, reiterated that participation was voluntary, and ascertained all participants were happy to continue. I also offered assurance when participants felt they had disclosed too much personal information about themselves. This process was necessary to ensure participants were protected and ensured trust throughout.

3:8:2.2 Disclosures and duty of care

I had anticipated that participants may feel distressed during the reflection and action phases, particularly when conscious of being audio-recorded. As the research initiator I offered myself as the one to approach for help should a co-researcher need support during the process. One of the participants who had disclosed a past mental health problem did not attend the next inquiry meeting. I called the participant to ensure everything was well, and assured them that the disclosure would not be shared elsewhere and would be anonymised should the story be included in the research. I also referred to the group's commitment to unconditional positive regard as proposed by Carl Rogers for counsellors and therapists (Cooper *et al.*, 2013), which encourages us to speak about our difficulties without fear of being criticised or judged.

We recognised the importance of self-care as the inquiry progressed, which meant that the group had the opportunity to self-reflect and process difficult thoughts and feelings with other participants. We had frequent breaks for fresh air or refreshments after intensive and stressful reflection, as suggested by Kettley (Kettley & Bates, 2015). I also ensured measures to safeguard any unexpected vulnerability by building in one-to-one meetings, or group

meetings/debriefings, and offered participants the opportunity to contact me at any time during the project's duration. I had a moral responsibility as the researcher for the well-being of my participants, especially when sensitive lived personal experiences had become part of our reflections - Tronto (2013) suggests researchers pay honest attention to the needs of their participants. Richards and Schwartz proposed that "the potential for distress to participants can be minimised by the researcher being clear about his or her role boundaries, and by ensuring that appropriate information and support are available" for participants should they need it (Richards & Schwartz, 2002, p. 137). As an example, Olu (not the person's real name), a participant, found it stressful reflecting on a vignette and I therefore contacted her during the break time to check if she was okay.

3:8:2.3 Limitations of the research

The principal limitation lay in the time constraint of the study, and participants therefore worked within a time limit on the action and reflection cycles, as described in sections 3:6:1.5 to 3:6:1.5d. The cooperative inquiry methodology has no time limit, the process of the actions and reflection continues until participants agree on an appropriate balance between a convergence or divergence on what is being explored (Heron & Reason, 2001). So, the question of when to stop was a tentative one.

We stopped whenever a consensus was reached on an issue, or when the conversation was leading nowhere. If the studies were to be repeated or designed again without time constraints or for a longer period it would allow more extensive discussions, the use of more vignettes and role play and, perhaps, more knowledge gained from further reflections. Although Southeast 1 was a smaller group the quality of the actions and reflections was as vigorous as Southeast 2. The strength of the research lay in the equal and open collaboration of the participants, which made the investigative aims of the study a reality.

The methodology offered all the researchers the opportunity to engage with the issues affecting them. Heron (1996, p. 102) suggests that exclusive

authorship is “a limitation on any claim that the findings of the inquiry are based on an authentic collaboration”. Reason and Bradbury (2001) propose that in a cooperative inquiry the participation of all is necessary if a study is to be authentic. The issue of authorship may also be a limitation of the study, as this thesis was not written collaboratively. It is my account as it was agreed with the inquiry group that I was to be the sole author, and it is important to acknowledge this position of as a limitation of the cooperative inquiry methodology.

However, McArdle (2004) suggests that exclusive authorship is not less collaborative and single authorship therefore no less valid - the written account is a way of presenting propositional knowledge gained from the inquiry, rather than the final truth from the participants.

3:8:3 Validity, Reliability, Generalisability

Guba and Lincoln suggest that for research to be considered trustworthy, it must reflect the intended reality of the participants (Guba & Lincoln, 1989, cited in Maher *et al.*, 2018). According to Heron (1996, p. 158), “the outcome of cooperative inquiry is valid if they are well-grounded in the forms of knowing; practical, propositional, presentational, and experiential” given the rigour and integrity of the study. Here I outline the strategy taken to free my data from distortion and to ensure my conclusions are valid.

First, by applying coherence as a criterion for validity, showing how the research findings cohere with each other, are consistent with each other, are interdependent, and mutually illuminating. The repeated cycles of reflections are a useful tool and enhance the validity of the findings. Building consensus, allowing collusion, managing distress, creating a balance between reflection and action, and between chaos and order were my validity strategies (Reason, 1996). Cho and Trent (2006, cited in Thomas, 2017) suggest continual contact of participants with each other and that building consensus is a significant validation technique.

In our inquiry meeting, the Christian leaders cooperated to facilitate a real sense of knowing. Grounded in their experience, and expressed through

stories and vignettes, they made the knowledge more valid, deeper, and richer (Reason & Heron, 1996). Validity was therefore strengthened by the democratic nature of the group through vocalised feedbacks and the agreed flip-chart summaries to establish the collective unity.

The thesis presents the knowledge gained from the inquiry through the collaborative process of the study. I have used direct quotes from participants to construct the report and give authenticity. With regard to genuineness, I have presented my account of the study as a doctorate submission and have confidence that this submission has validity. I have judged it to be a fair account of the research, recognising that each participant may have different perspectives of the journey. This report is part of the writing-up process and is not the final truth that speaks for all participants. McArdle (2004) suggested owning one's story is a way to give recognition to the work of the inquiry group.

The data was reviewed by all the participants throughout the inquiry cycles to ensure that it was credible and accurate. The participants' consensus on the themes (captured on the flip-chart) was checked with the voice recording for accuracy and provided the researcher with the context of the conversation. Reason (1988) suggests that validity is enhanced when the participants agree with the conclusions. The emerging themes and categories, the analysis and interpretation were described and mapped in Appendices 11-16 to show consistency and transparency. The thematic and Bourdieusian maps illustrate the evidence from original data used to develop the categories, and further demonstrates the validity of the research (Appendices 16 & 19).

Generalisability

How is this research relevant to a broad Christian audience? The extent to which the findings of the thesis could be applied or theoretically imported to the wider Christian world and other faith communities are discussed here.

Smith (2018) suggests the legitimate extension of research findings and conclusions from a study, gained from reliable results of a representative sample of participants, can be applied to a wider population or different

contexts. Generalisability needs data from large populations, quantitative and experimental research, to provide the best foundation for broad generalisability. The larger the sample population the more confidently one can generalise the results (Barnes *et al.,* 2012).

Lewis *et al.* suggest "qualitative research cannot be generalised on a statistical basis" (Lewis *et al.,* 2014, p. 351, cited in Smith, 2018). This thesis uses stories or vignettes from the participants and as a qualitative study it is impossible to generalise the findings. The researcher assumed that the results may be transferable as the 15 Christian leaders cannot represent leaders of all Christian denominations. The findings drawn from this research are only about the participants being observed, and therefore cannot be generalised into a wider context.

However, the study highlights the challenges faced by the participating Christian leaders caring for congregants with mental health issues and offers insight into their training needs and how to collaborate with mental health professionals. The findings are unique to my participants and it cannot be predicted how this study may be applied to others, however other faith community leaders may find the study useful. The use of representational generalisation is a helpful way to describe similarities and differences in the findings, as readers may be familiar with the issues addressed by the research (Lewis *et al.,* 2014). The findings will resonate with the tacit experiences of readers (Stake, 1978). Does this research reverberate with pastors or leaders of a different faith community? Or will the data and the results speak to their experience? The researcher has provided evidence of participants' details, the vignette materials and expression to help readers reflect upon them, make connections to their own lives and faith community situations. The research does not make any broad claim as to the generalisability of its findings.

It has revealed the challenge for pastors circulating within the NHS culture in ways that enable them to support their congregants. It has also identified the need for support for leaders in how they operate with theological integrity in this context. Although the results from the research are not generalisable, the

richness of the research offers readers possible insights that may well resonate with their own experience. It invites readers to make connections between elements of this study and their own experience.

Chapter 4 Applicability of Bourdieu's Concepts to the Analysis

4.1 Introduction

In this chapter, I will describe the background to the work of Pierre Bourdieu that influenced his social theory, and discuss how that theory was used to critically analyse and interpret my data in this research.

Bourdieu was French, born in 1930 and died in 2002. He lived a large part of his life during the eventful 20th century when there were great changes, including two world wars, geopolitical reforms, the cold war, the rise of socialist states, and anti-colonial movements (Grenfell, 2014).

According to Medvetz and Sallaz (2018), Bourdieu graduated with a degree in philosophy from the *Ecole Normale Superieure*, where notable intellectuals like Durkheim, Sartre, and Foucault attended. After graduating from university, Bourdieu taught for a year at a *lycée* in a small town in France and then enlisted within the French military and was deployed to Algeria in 1955 (Medvetz and Sallaz, 2018). In Algeria, Bourdieu found himself caught up in the rebellion of the colonised people of western empires against their colonists. France and other Europeans held colonial power around the world for centuries. Bourdieu remained in Algeria as an educator and researcher until 1960 (Medvetz and Sallaz, 2018). Bourdieu conducted his first fieldwork in Algeria, among the Berber-speaking Kabyle. His anthropological investigations were empirical, and his empirical work informed much of his later theoretical writings (Wacquant, 2004). Bourdieu's experience in Algeria, as well as witnessing the French state's plan to hold on to colonial power, influenced his comprehensive theory of field and power dynamics in society (Goodman and Silverstein, 2009).

By integrating theory and empirical research, Bourdieu sought to understand how theory impacts everyday work and practices (Medvetz and Sallaz, 2018). Bourdieu was interested in the relationship between structure and agency and his sociological concerns (Bourdieu,1984) were to understand the practical

logic of everyday life and how society limits, influences, and impinges upon our behaviours. By understanding the general organisation of society in relation to power, one can explain the way to dress, wear, eat, display things on one's wall, and what movie to watch. Burawoy (2018) argues that Bourdieu offers us a methodology for thinking about "the relationship between social science and lived experience, the logic of theory and logic of practice" (p.13).

Marxism played a role in Bourdieu's work, yet his theoretical framework is a complex combination of Marx, Weber, Durkheim, Merleau-Ponty, plus a great deal of conceptual development that is uniquely his own (Reay, 2004; Burawoy, 2018). Drawing on Max Weber, he highlighted the dominance of symbolic systems in social life, as well as the idea of social order, which was later developed into the theory of fields (McKinnon, Trzebiatowska and Brittain, 2011). Marxism played a role in Bourdieu's work, yet his theoretical framework is a complex combination of Marx, Weber, Durkheim, Merleau-Ponty, plus a great deal of conceptual development that is uniquely his own (Reay, 2004; Burawoy, 2018). Drawing on Max Weber, he highlighted the dominance of symbolic systems in social life, as well as the idea of social order, which was later developed into the theory of fields (McKinnon, Trzebiatowska and Brittain, 2011). Marx's influence can be seen most clearly in Bourdieu's theory of cultural capital. Like Marx, Bourdieu argued that capital dictated one's position within society (Reay, 2004). According to Weininger (2003), Marx and Bourdieu proposed that the more capital one had, the more powerful a position one occupied in society. Bourdieu subsequently expanded Marx's notion of capital beyond economic production and into the realm of culture, which now refers to the collection of symbolic elements like skills, tastes, posture, and credentials (Weininger, 2003). A key objective of Bourdieu's research is to uncover the hidden structures of the social world and the methods that ensure their reproduction and transformation (Bourdieu, 1996).

Bourdieu's main concepts are field, capital and habitus. Bourdieu writes that all of his thinking was based on how behaviour can be regulated without following rules (Bourdieu, 1990b, p. 65). For Bourdieu, the habitus is what

organises the social world, and actions are dependent on how others are expected to respond. The notion of habitus is how Bourdieu interconnects agency (practice) and structure (capital and field). For example, in my research, the religious field features a markedly different habitus from the professional field of mental health, because of the distinctive medical qualifications, knowledge, status, prestige, and power of the inhabitants of the latter field. Bourdieu's theory of social practice explains how power relations are interwoven and applied in and between fields. It seeks to make sense of power struggles through the resources, history, or practical experiences that influence social change. Pertinent to research in education, Green suggested that Bourdieu's theory provides educational research with a set of concepts, that reveal and make understandable the complex relationships between assumptions people make and the institutional power structures within the social space (Green, 2012, p. 11).

Accordingly, this thesis employs the analytical and theoretical tools of Bourdieu's concepts of field, habitus, and cultural capital to draw out participants' perspectives and institutional assumptions, and to rearrange, describe, and explain the research findings. The Bourdieusian concepts are used to conceptualise the intersection between the religious field of Christian leaders and the professional field of the NHS. Field, habitus, and cultural capital concepts enabled me to be realistic in understanding the challenges for Christian leaders and the tensions at stake when they function in another setting.

The tensions between psychiatry and religion, as discussed in Chapter 2, suggest that science and faith may be fundamentally incompatible (Pargament & Lomax, 2013; Sullivan *et al.,* 2013). Hostility between the two included Christian leaders discouraging congregants from consulting with a psychiatrist for their problems, and psychiatrists considering the teachings of churches as causative of mental illness (Pargament & Lomax, 2013). Despite the fact that the relationship between religion and psychiatry has survived the mutual suspicion and open hostility (Sim, 2003), they are forced to get along with each other (Pargament & Lomax, 2013; Sim, 2003) amidst tensions

caused by mutual fears and suspicions in the mental health field of the NHS. Bourdieu's (1977b, 1990) concept of field, habitus and cultural capital allows me to explore and conceptualise the tension between the medical world of psychiatry and the religious world of Christian leaders in greater depth. First I am going to look at how Bourdieu conceptualises the different dynamics of the religious field, and secondly discuss how Bourdieu's categories reveal the power dynamics at work in the religious and mental health fields.

4.2 The different dynamic of the religious field of Christian Leaders

Bourdieu defines field in analytical terms as:

> a network, or configuration, of objective relations between positions. These positions are objectively defined, in their existence and the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.) (Bourdieu and Wacquant, 1992, p. 97).

In this Bourdieusian definition, a field is a free space of activity that responds to rules of functioning and defines the relationships among those who occupy it (Hilgers & Mangez, 2015). Bourdieu (1993) also suggests that a field is a "field of forces" and those who control it through their status and authority compel agents who are in it to accept the implicit field-specific rules (Bourdieu & Wacquant, 1992). Emirbayer and Johnson (2008, p. 6) propose that a field is "a temporary state of power relations within what is an ongoing struggle for power" (cited in Grusendorf, 2016). In the context of this study is the idea that religious leaders exercise power and dominance in the religious field. The religious field within which Christian leaders operate is comprised of both those who control and those who are dominated, thus creating a field of consistent and lasting relationships of inequality and confined to the position to receive religious goods and services, managed by

church leaders and officials (Bourdieu 1991a, p. 23). According to Poling (2005, cited in Shupe, 2007), the official titles in the religious field lead congregants to view them with awe, they become the resource within their communities and are seen to have an immense influence on the health behaviour of their congregants. This field-specific cultural capital of the institution, and embodied knowledge and skills related resources define positions to influence or dominate the field (Doblytė, 2019).

According to Dillon (2001, p. 418, cited in Grusendorf, 2016), a religious field can be a space that promotes equality and respect in contrast to the favouring of the autonomous authority of Christian leaders or church officials. But Shupe (2007) suggests that the religious field represents a unique type of power unlike the mental health field, where those occupying "lower status in the religious field are encouraged to trust in the spiritual insights and wisdom of their leaders" (2007, pp. 6-7). Religious groups and institutions as hierarchies of unequal power give Christian leaders powers of moral persuasion and, in some, theological authority to deny others access to membership and even ultimately the hope of eternal life (Shupe, 2007).

The sociology of religion developed by Bourdieu is principally a study of French Catholicism and focuses very much on the monopoly of power in relation to the Catholic institution (Bourdieu, 1991a; Dianteill, 2003; McKinnon, 2017). Bourdieu's sociology of religion from this point of view depends on a particular social situation and its links with the state and institution (Dillion, 2001). From this stance, the hierarchy of the church is the producer of ideology, where the laity is "more acted on than they are actors" (Burns, 1992, p. 29, cited in Dillion, 2001, p. 414). The Bourdieusian framework emphases "religious specialists", or Christian leaders as holders of the specific capability essentially designed for the production and reproduction of a deliberately "organised corpus of secret (and therefore rare) knowledge." Bourdieu juxtaposed these religious specialists with the laity who are objectively "dispossessed of religious capital" (Bourdieu, 1991a, p. 9, cited in Dillion 2001, pp. 414-415). Bourdieu (1991a) saw Christian leaders as specialists with religious capital and distinguishes them from congregants

(laity) as consumers of religious interpretation and guidance, limiting laypeople to the position of consumers of religious goods and services, produced by either pastors or Christian leaders. According to Swartz, (1996, p. 74), Bourdieu's construct is "a general theory of the economy of practices" that will analyse "all practices" as "aimed at maximising material or symbolic profit".

Dianteil (2003) questioned the generalisation of Bourdieu's thinking to other religious contexts, including Catholic churches elsewhere. In comparison, Bourdieu's religious capital addresses French Roman Catholicism, which conceptualises its establishment around the power distinctions between priest and congregation (McKinnon, Trzebiatowska & Brittain, 2011), Dillon (2001, pp. 413-419). In contrast to the church officials' independent authority, Dianteil argues for an egalitarian dynamic of the religious field.

Rey (2004 p. 340) asserted that Bourdieu's emphasis on the networks of power is weak as it does not address other communities like denominations or congregations (cited in Guest, 2007). Motak (2009 pp. 130-133) argued that Bourdieu's theoretical framework could not handle the complexities of the contemporary religious landscape, expanding spirituality to include all to include all other religions with or without the traditional religious theological and dogmatic expressions. Danto (1999) suggests that, despite the different outlooks and complexity, Bourdieu's concept offers an excellent way to observe the interactions between Christian leaders and congregants for useful insights into the religious field (cited in Grusendorf, 2016, p. 3). McKinnon, Trzebiatowska and Brittain (2011, p. 356) suggested that Bourdieu's concept of the religious field offers a beneficial lens for looking at the tensions between Christian leaders and congregants.

Diantieill (2003) described Bourdieu's concept of the religious field as a controlling institution, which promoted a view that saw the religious field as a single ruling body with a historical link to the state. This view saw the religious field as one in competition with the field of labour, that is, it takes power from church members and gives it to the church professional,

authorised by the religious field itself. In contrast, Dillon (2001) argues that power does not rest with the Christian leaders, but the most active religious field is one where the professionals and the laity share power equally. Given the insight it provides into the operation of religious institutions and groups, Bourdieu has more to offer to the analysis of the religious field in this research and I will extend the logic of practice to identify status (prestige), power (authority), knowledge and legitimacy. This will be explored in relation to Christian leaders in the mental health field of the NHS to understand the relationship between their congregants and the medical professionals.

4.2.1 Field: NHS and Religion

As explained in Part 4:2, the medical or healthcare field is as a social context in which doctors and healthcare professionals act and invest in becoming successful in their field of work (Carlhed, 2007, cited in Olsson, Kalén & Ponzer, 2019), using their various forms of capital to contest over possessions and positions (Witman *et al.*, 2011, cited in Olsson, Kalén & Ponzer, 2019). Bourdieu, (2011) suggests that the players in the medical field struggle to gain different forms of capital, either cultural, economic, social or symbolic, to gain the status required to be successful within their field. So the agents for this study, mental health doctors, fight over resources to gain attractive positions in the medical field (Olsson, Kalén & Ponzer, 2019).

The hierarchical structure of medical professionals is symbolic of social prestige, status, power and recognition, and is the agent with the symbolic capital that controls the field. Therefore, status and prestige within the medical field of the NHS help us to understand and make sense of the relational dynamics between Christian leaders, congregants and mental health professionals within the field (Hindhede & Larsen, 2018, cited in Olsson, Kalén & Ponzer, 2019). The NHS field can be characterised by the contest between dominant "position-taking" (Bourdieu, 1993), that is claims of medical achievements to legitimise status and those of subordinate actors such as patients (congregants) or allied health professionals such as chaplains and pastoral carers (Collyer *et al.*, 2015).

The field that is explored in this thesis is the mental health field of the National Health Service (NHS), comprising the relationship between mental health professionals, Christian leaders and congregants with mental health needs. The field context provides a stronger and a more subtle insight into the relationship between mental health professionals, church leaders and congregants. As already pointed out, Bourdieu (1977a) suggested the field is an integrated space of occupants and institutions which interrelate with each other by field-specific rules that are not formalised but implied in nature (Wacquant, 2011), and internalised by its occupants to demonstrate appropriate practices and strategies (Bourdieu, 1977b). A mental health field is then a place of competitive struggles for a position, that aims to either preserve or transform the present relations of force (Cock *et al.,* 2018). The interaction between the different positions occupied by the mental health professional, Christian leaders and congregants (people using services) in the field makes changes to transform the field (Bourdieu, 2011). The insight generated from the data and the creation of a training programme is intended to bring about the transformation.

Medical practitioners in the mental health field are influential professionals who dominate (Crossley, 1999) and are perceived as the elite of the practice of mental healthcare, with a legitimate form of power or authority in the field. According to Roberts (2005) the,

> existence and exercise of power has gained increased importance within psychiatry, psychotherapy and mental health nursing and the everyday examples such as seclusions, locked hospital wards and compulsory admission and treatment of people under the Mental Health Act 1983, are all different degrees of the existence and exercise of power within psychiatry (Roberts, 2005, p. 8).

The logic in justifying psychiatric authority appears to be the assertion of expert knowledge in the diagnosis and treatment of mental disorders (Bracken, 2012; Samson, 1995). Also, the current legal framework governing psychiatric interventions endorses the singular authority of psychiatric

science (Bracken, 2012). Samson (1995, p. 252) noted that the psychiatrist is both "intellectually and clinically superior to other professionals" due to their field-specific capital such as exceptional capacities to diagnose and treat mental illness as well as understanding the wide range of associated problems. Therefore, those trained outside medical schools, such as Christian leaders from the religious field and others in the mental health field, are seen as having less wide-ranging skills than the psychiatrist and therefore less capital (Samson, 1995).

Brophy *et al.* (2019), Sashidharan and Saraceno (2017), and Dawson *et al.* (2016) suggest that a greater dependence among clinicians on risk assessments and the use of community treatment orders endorsed coercive psychiatric practices, which they saw as harmful to the professional responsibility of caring. The existence of legitimate authority within the mental health professional field is further enforced by a professional register and standards, declaring the identity and authority of the profession (Sashidharan & Saraceno, 2017). The field of psychiatry as a regulated institution, with the power to describe the authentic psychiatric practice and education therefore has constructed a dominant, influential and powerful role for itself within the National Health Service (Samson, 1995). The overall structure of the mental health field and the positions taken by psychiatry means it is a "powerful force" in the field (Gray, 2018). The field of mental healthcare is a site of symbolic power, which perhaps results in a subtle or 'invisible' form of domination over the Christian leaders and congregants (Bourdieu & Wacquant, 1992; McNay, 1999, cited in Doblytė, 2019). Bourdieu (1989, p. 63) draws attention to "the very exercise of the clinical act implies a form of symbolic violence" and, correspondingly, influences the practices of the field. Therefore, the best-positioned agent with specific capital is granted recognition and the right to exercise authority in the field (Cock *et al.*, 2018).

4.2.2 Cultural capital: NHS and religion

Bourdieu (1986) developed the concept of capital to explain forms of values deployed within a social space of interactions, and this will be useful in

interrogating the relationships between mental health clinical professionals, Christian leaders and people using services (congregants) with religious persuasion. Economic, social, cultural and symbolic capital are the key ideas for creating, preserving and reproducing social relationships in the practice of the mental health field (Montgomery *et al.,* 2020). Bourdieu (1986, p. 252) suggested that economic capital is principally composed of the resources of income and property, and it is the foundation of capital in the field.

Montgomery *et al.* (2020) suggested that economic capital emphasises the physical objects, such as buildings and artefacts. that establishes visible affluence within a particular field of practice. Social capital, in contrast, are the resources connected to the "possession of a durable network of mutual acquaintance and recognition" (Bourdieu 1986, p. 248). According to Callaghan and Wistow (2006), cultural capital concerns the cultural competencies individuals develop through socialisation and learn over time, and capital can be incorporated as skills and knowledge, objectified in books or tools, or institutionalised as degrees or certificates (Abel & Frohlich, 2012, p. 238, cited in Collyer *et al.*, 2015).

Dagkas and Quarmby (2012) suggested that culturally recognised attributes and competencies of players of the mental health field are strongly interlinked to how individuals control the arrangement of that particular field. According to Callaghan and Wistow (2006) cultural capital (professional and academic qualifications) is the primary source of professional and decision-making power in the health service. Symbolically, it expresses more intangible elements of reputation and social standing and is deployed to maximise individual position in a field and the particular distribution of power is the outcome of their interplay (Bourdieu, 1999, cited in Callaghan & Wistow, 2006).

The professionals in the NHS field owe essential field-related cultural and symbolic capital that empowers them to exercise power in their institution decision-making structures and possess the potential to restructure and influence that field (Fowler, 2020). According to Callaghan and Wistow

(2006), cultural capital has endowed professionals with a strong claim to authority and prestige. According to Bourdieu (1986), capital in its objectified (visible, material assets), embodied and institutional form provides the power to influence professional participation. In the field of the NHS and religion (Christian leaders), cultural capital provides the bases of dominance to enhance position and status to establish its hierarchical power structures (Shilling, 2003; Pinxten & Lievens, 2014). Bourdieu (1973, p. 258, cited in Schroeder, 2016) suggested that cultural capital in institutional structure controls the movement of individuals with limited category to preserve existing class structures and in its institutional habitus perpetuates inequalities, class power, status and privilege in the mental health field. The diverse form of cultural capital associated with the different ways of expectation is used to preserve demarcations between the Christian leaders and mental health professionals to strengthen field-related hierarchical divisions (McDonald, 2014).

Both the Christian leader and mental health professional have relevant cultural capital in the context of their particular fields, and the value of their cultural capital is only applicable in relative situations (Bourdieu, 1993). For example, as already argued, the mental health professional is highly respected in the mental health field by relevant cultural capital and experiences that allow the navigation of the mental health space. Equally, Christian leaders have qualifications and experiences relevant to their religious field. Still, it seems that their cultural capital in the mental health field cannot be transferred into economic capital (Bourdieu, 1993) because the specific form of knowledge relevant to that field is privileged, such as mental health knowledge. Christian leaders' cultural capital cannot be the same as that of the psychiatrist as the number of resources they accumulate and exchange are not transferable, or always relevant. Therefore, in applying a Bourdieusian lens to the data, the varying differences of interaction and communication of the experience of congregants become apparent - for example, the proficiency and knowledge conferred by cultural capital related to clinical mental health practices on congregants.

The way ministers take care of congregants using mental health services are typically developed and implemented by individuals comprising a mixture of professionals from different academic disciplines, and the care of the individual involved is varied depending on the institution. These professionals engage in dialogue with each other about the best care for the congregant. People using mental health services (congregants) often express their desire to participate in the decision regarding their care, particularly hospital admissions and medication (Adams, Drake, & Wolford, 2007). Many congregants report that their perceived role in decision making regarding their care is usually passive. The joint decision is not a widely dispersed practice in everyday psychiatry management of congregants; reports suggest psychiatrists say the mutual decision does not apply to decisions regarding medications and hospital admissions for capacity reasons (Hamann *et al.*, 2009). If care practices are fundamentally communicative, then understanding the field of mental health of the professional who defines the rule and preferences of the field may help to draw out patterns to explain the needs of congregants. The inequality created by the unequal conditions based on status and the amount of cultural capital determines what is imaginable, credible, or impossible in the hierarchy of the mental health field. When the Christian habitus encounters the professional habitus in the mental health field, which they are not familiar with, it may result in a separation or disconnection, causing a resistance or compromises that may result in a change or transformation. The interlink between the cultural capital and habitus in the mental health professional field and has a destabilising implication because of power relations, and despite any misunderstandings, both Christian leaders and professional in the mental health field, can work together to generate practice (Bourdieu, 1984; Dumais, 2002; Bourdieu & Wacquant, 1992).

4.2.3 Habitus: NHS and religion

Bourdieu (1990a, p. 59) outlined habitus as "a system of dispositions" or a system of long-lasting acquired schemes of perception, thought, and activities; embodying systematic habits that lead individuals to act in a

reactionary or non-reflexive way to generate and organise practices. The mechanism of practical functions of individual and collective in the field, cultural capital and class status produces the habitus. It is a living history, a way of life embedded in "deeply rooted assumptions, not explicitly reflected upon but held almost subconsciously, which stem from a worldview" (Green 2012, p. 12, cited in Grusendorf, 2016).

Costa & Murphy (2015, p. 4) expand the concept of habitus by stating that it is an "agent of continuity and tradition as a force of change." Brown and Gary (cited in Barrett, 2010) included psychological affirmation such as individual well-being, emotional support, and values viewpoints, actions, and practices (Regnerus, 2000, cited in Barrett, 2010), shaping what Glanville *et al.* (2008, p. 128) term a habitus (cited in Barrett, 2010). Habitus is developed through socialisation within the field of mental health and religion "integrating past experiences, functions at every life as a matrix of perceptions, appreciations, and actions" (Bourdieu, 1971, p. 83). Habitus is concerned with issues about success, power, status and prestige and controls how we "categorise, organise, select and configure the material and cultural resources we employ in our behaviour" (Moore, 2004, p. 80, cited in Barrett, 2010).

The usefulness of Bourdieu's notion of habitus is subject to debate. Archer (2012) pointed out that using habitus to understand the lives of individuals is limited in the rapidly changing global contexts of the present, and Archer argued that the limitations call for the abandonment of the concept of the habitus (Archer, 2012, pp. 58-9, 76, cited in Mellor & Shilling, 2014). Mellor and Shilling (2014) supports the use of habitus and argues that it is possible to reconstruct the term productively in today's world to understand the social and cultural complexity of the present (Lahire, 2011, cited in Mellor & Shilling, 2014, pp. 3-4).

Despite the debate about its usefulness, the concept of habitus can help us examine professional conflict, the embodied dispositions, routinised practices, and to understand the interaction and conversation practice within the field of mental health and its impact on Christian leaders and congregants.

The structuring of the mental health field can be understood in Bourdieusian terms when the three concepts are brought together into an interlinked and dynamic plan.

The structure of the mental health field is inside the habitus, which is both a "structured and structuring structure" (Bourdieu, 1984, p. 171), occurring through the interplay and interaction of the various forms of the cultural capital where individual practices are associated with those of the social group or class (Collyer *et al.*, 2015). According to Bourdieu and Wacquant (1992, p. 127), the field gives the habitus structure and acts as the vehicle through which the various capitals are produced and socially distributed (Moore, 2008, p. 105). In this way, according to Collyer *et al.* (2015), the mental health field structures', logic, and forces empower or suppress the authority of Christian leaders or mental health professionals to shape the field's decision-making.

The habitus, which includes the perceptions and actions of Christian leaders in the mental health field, is challenged to reproduce or adapt to the rules of the new field (Crossley & Crossley, 2001, cited in Walther, 2014). This evolving habitus will continue to adjust to the mental health field and be strengthened by further experience (Mayrhofer *et al.*, 2007, cited in Walther, 2014). Christian leaders internalise and externalise specific field related issues to develop the capacity and language to speak within that particular field (Hage, 2009). To adopt field related capital enhances the Christian leader's position in that field with the chance of succeeding to determine the right cultural capital of the mental health field (Bourdieu, 1984; 1990a, cited in Yang, 2014; Bourdieu & Passeron, 1977). As the experiences become embodied in the mental health field, the Christian leaders develop and learn the rules, which will become second nature (Bourdieu, 1977b). The thesis argues that Christian leaders and those congregants who feel inherently disadvantaged in the mental health field struggle to make their voices heard within the habitus of mental health, due to the newness of the language and their lack of confidence in voicing their views.

The thesis found that there was a distinctive religious form of capital the habitus preserved only for the official priesthood or Christian leaders (Guest, 2007), that produces and reproduces competence and status to maintain the distinction between Christian leaders and their congregants (Bourdieu, 1991b, p. 10, cited in Guest, 2007).

The inequality and mutual dependence of Christian leaders and mental health professionals suggest the need for a valuable commitment to collaborate and exchange with each other on the logic of the field (Hodkinson, Biesta, & James, 2007, cited in Bathmaker, 2015). Establishing a possible exchange between different mental health perspectives, noting the "different forms of capital" within mental health care should reveal potential areas that need attention for training (Bourdieu, 1986). The unconscious and conscious practice of the religious and mental health professionals make choices and develop strategies as they engage with themselves in deploying new forms of capital. A Bourdieusian approach to interrogating data can clarify the Christian leader's position in the mental health field, pastoral practices with congregants, and the influence of religious structures, issues of power and status on congregant and the competing habitus within the mental health field to draw relevant themes about the training needs of Christian leaders.

4.3 The use of Bourdieu and the emergent social theoretical model

Bourdieu's theoretical model, as I have set out in this section, is perfect for the study as the concept of field, cultural capital and habitus capture the interaction between the two fields. It crosses both religious and mental health fields to explain, understand, interrogate and examine, to establish and formulate assumptions and categorise findings to allow the detailed analysis between the dynamic activities of both the religious field and the mental health field. The framework provided the research with a tool to understand the relationship between church leaders, congregants and mental health professionals and offers the thesis a way of exploring the disparities that occur in a social space of interaction in the mental health field.

Through the notion of field the study conceptualised the religious and mental health fields as a space where the struggle existed and persisted. The Bourdieusian concepts of capital, habitus and field as tools frames an analysis of Christian leaders' embodied experiences, status, power relations, actions and performance in the mental health field (Bourdieu ,1977b). It provided an insight into the assumptions and deeply held dispositions rooted within the religious field; and drew out the viewpoints and established beliefs of the Christian leaders to inform the discussions of the findings theoretically. This practice revealed the power dynamics and issues of authority experienced by Christian leaders caring for their congregants who are using a mental health service. I have also applied the symbolic power of Bourdieu's theory to explain subtle power issues in the field. These unconscious dispositions may help us understand matters of domination, recognition and inclusion. It may also explain the struggles of Christian leaders and the subtle symbolic violence they face in caring for their congregants with mental health issues. Therefore, the theory brings to light the relational dynamics between the mental health perspectives of the Christian leaders, other mental health professionals and congregants, to attempt to define how the perceptions and beliefs of Christian leaders interact with practices in the mental healthcare system.

Using the Bourdieusian concepts of field, cultural capital and habitus to investigate the data will unearth new insights into how the power dynamics and relationships between the fields understand the needs of Christian leaders to inform a curriculum to transform the mental health practice of Christian leaders.

I will take Bourdieu's concepts of capital, habitus and field, emphasising the relationship between them, to generate practices that contribute to a new way of working with congregants. Mills (2008) suggests that there is transformative potential using Bourdieu's theoretical constructs for the religious field to improve the educational outcomes of Christian leaders to bring about new ways of caring for their congregants.

The religious field, according to Emirbayer and Johnson (2008), is in pursuit of a particular form of capital that overlaps with the field-specific capital of the mental health field, creating different assumptions and expectations. They, therefore, compete with one another in the field about shared capital (Green, 2012), causing the various individuals within the field to compete for attention (McAlexander *et al.,* 2014). The Christian leaders whose place and stance "clash with the prevailing norms of production and the expectations of the field cannot succeed without the help of external changes" (Bourdieu, 1993, p. 57, cited in Maanen, 2009, p. 72). The "lack of recognisable status symbol", habitus dislocation, and mismatch between expectations and constraints (Nairz-Wirth, Feldmann, & Spiegl, 2017) reduce the overall ability of the Christian leaders to respond to the mental health needs of congregants.

In the mental health field, the Christian leaders need to learn to adopt relevant mental health field of practice, forming a trusting relationship with the mental health professional to acquire approaches of care that can defend or improve their positions within the field. The habitus of Christian leaders and mental health professionals in the mental health field have unique field-related capital that enhances the care of congregants, and the interaction between Christian leaders and congregants bring to this mental health field a unique religious understanding. The cultural capital of the two practices and their interaction with the structures of the mental health institution enhance congregant ability to develop relevant cultural capital to manage their religious needs (Collyer *et al.,* 2015). Shim, (2010, p. 8, cited in Collyer *et al.,* 2015) suggests a co-construction of resources, particularly given a more significant choice through the interaction between the mental health professional, Christian leaders and congregants; such broader interactions in the field increase the resources that support the religious needs of congregants. The interaction between the cultural capital of the professionals in the mental health field and Christian leaders give voice through the dialogue to define problems and emerging issues. Montgomery *et al.* (2020) suggest that hierarchy and power dynamics between health professions can

be a significant barrier to true collaboration. I have used Bourdieu's concepts to demonstrate ways in which power, status and prestige and legitimacy create unequal dispositions in both the mental health and religious fields.

4.4 Conclusion

The Bourdieusian theory of field is used in the analysis to provide a much more robust interrogation into the influences and relationship that exist in the religious and NHS fields by exploring the different cultural capital and habitus to understand how status, power, authority and legitimacy operate in the two fields. This approach offers a new perspective to previously underexploited dynamics, in understanding the intersection between the religion and mental health fields in the care of congregants. Bourdieu's conceptual tools of habitus, cultural capital, and field offer a lens to understand how cultural capital from the mental health field is converted into a viable religious capital in the religious field for Christian leaders to better engage with congregants. Bourdieu's ideas offer a powerful 'theoretical lens' for the research. As a thinking tool, it supports my principal argument in this thesis that exploring the religious field of Christian leaders and the expectation of congregants and their experiences of the mental health field will provide insight into the leaders' training needs.

Chapter 5 Data Analysis and Findings

5:1 Introduction

This chapter contains the analysis and findings from the fifteen cooperative inquiry participants as detailed in the methodology chapter. The aim was to explore the following research question:

> *A cooperative inquiry:*
>
> *What are the training needs of Christian ministers so that they are better equipped to fulfil the spiritual and pastoral care needs of members of their congregation with mental health issues? The insight from this research will provide a curriculum for the training of Christian ministers.*

This chapter will include an example of demographical data to support the summary, and a detailed flip-chart overview of the findings from Southeast 1 and Southeast 2, analysed to uncover codes and themes within the data. Thematic analysis (Braun & Clarke, 2006) is used to generate the codes and themes; and Bourdieu's (1977b;1984;1990) concept of habitus, cultural capital and field is used to provide a theoretical understanding that underpins the themes and categories derived from the thematic analysis of the dataset.

5:2 Thematic Analysis

Braun and Clarke suggest that thematic analysis offers flexibility in enabling, analysing and reporting the experience, meaning and reality of participants, and is an excellent method for "identifying, analysing, and reporting patterns (themes) within the data" (Braun & Clarke, 2006, p. 97). Thematic analysis is a rigorous method and gives insight into developing codes and categories from the data set. The primary data consisted of flip-chart summaries, transcripts of audio recordings and my reflections on the cooperative inquiry meetings. The analysis captured the semantic and latent (interpretative level) meaning within the dataset (Boyatzis, 1998; Braun and Clarke, 2006; 2013) and the semantic approach identified themes from the precise and surface

meaning of the data. The analytical process includes a description of the data organised to show patterns in the semantic content, summarised and interpreted. Braun and Clarke (2006, p. 79) also propose that a rigorous thematic analysis can produce accurate and insightful findings and is the best method to identify, analyse and report patterns (themes) within the data, as well as the interpretation of it (Boyatzis, 1998).

Braun and Clarke (2006) emphasise the need for the researcher to have an active role in recognising patterns or themes and choosing which ones are of interest, with the analysis created by the researcher. A theme is something significant captured in the data about the research question and represents a level of patterned response or meaning within the data (Braun & Clarke, 2006).

According to Terry *et al.* (2017) good coding is open and inclusive, there are no 'right' or 'wrong' codes, the codes generated however need to be meaningful to the researcher, capturing the interpretation of the data related to their research questions. However, Braun and Clarke (2006) suggest that the investigator's decision is essential in determining a theme from the dataset and must capture the significant idea in the research question. The thematic analysis was therefore driven by the reoccurrence of relevant codes, noticing the prevalence of codes in the summary notes of participants. There are no right or wrong ways of determining prevalence, but the researcher was consistent regarding relevant patterns within the analysis (Braun & Clarke, 2006).

5.2.1 Coding Stages

Braun and Clarke (2006, p. 87) produced a six-phase, step-by-step guide to thematic analysis:

1. Familiarisation with the data: this involves transcribing the data, reading, and rereading the data, noting down participants' initial ideas.
2. Generating codes: producing concise labels to identify significant features of the data relevant to answering the research question.

3. Looking for themes: the collating of codes into potential themes in order to identify significant broader patterns of meaning relevant to the research question.
4. Reviewing potential themes: checking the researcher's themes against the dataset, to see if they tell a convincing story that answers the research question.
5. Defining and naming themes: developing a detailed analysis of each theme, generating clear definitions to confirm the whole narrative in the dataset.
6. The producing of the report: writing up, weaving together the analytic narrative and data extracts.

The researcher used the stages outlined above to derive meaningful and defensible clarifications and adopted these key stages to address the core analytic engagements with the collected dataset. Richards and Morse (cited in Saldana, 2009) point out that coding is heuristic and that it is an exploratory, problem-solving technique without specific formulas to follow. Coding is not just labelling; the researcher linked the ideas within the dataset together as suggested by Richards and Morse (2007, cited in Saldana, 2009, p. 8). In practical terms the researcher coded phrases, used whole sentences in line with the philosophical assumptions of the study, and followed the systematic steps provide by the thematic analysis model to inform the conclusions (Braun & Clarke, 2006, p. 87).

There are assumptions to consider within the thematic analysis approach before using the model and I will discuss them here to consider how the codes were used.

An 'inductive' approach identifies themes linked to the data (Patton, 1990), which may bear little resemblance to the questions explored by the participants. The inductive analysis coding is a data-driven analysis and does not fit within an existing coding frame of the researcher's analytic preconceptions (Braun & Clarke, 2006).

A ‘deductive’ or ‘top-down’ approach involves approaching the data with defined themes that the researcher expects to find reflected in the data, based on his theory or existing knowledge. Here, coding is affected by the researcher’s theoretical or analytical interest in the research area and the analysis is therefore researcher-driven.

Another decision concerns semantic or latent themes. As stated in section 5:2, a semantic approach analysis captures meanings explicitly stated in the data, so the words are taken at face value. Conversely, latent analysis captures essence not expressly stated in the data, including ideas, assumptions or concepts that underpin what is explicitly stated. Finally, the data analysis should consider the researcher’s ontological, epistemological position.

The researcher’s interpretive constructivist approach proposes that meanings are constructed, and that the interpretation offered is based on the participants, in the sense that data is interrogated to generate meaning or knowledge of the participants and not to test a theory. As the researcher is personally involved in the participants’ experiences, he cannot be detached from the study. So, I take the interpretive and constructivist position to emphasise the mutually close relationship between the researcher (myself) and the researched (the participants (see Chapter 3:4, pp. 34-38) to suggest that the knowledge gained from this research was from the participants’ reflection and interpretations of their experience. All choices informing the analysis were to identify patterns in Christian leaders’ experiences with congregants with mental health issues.

In summary, this investigation explores participant experiences using the framework of interpretive constructivism (Denzin & Lincoln, 2005). As discussed in Chapter 3:4 (pp. 34-38), the Christian leader’s reality is constructed through the interpretations of their experiences with their congregants.

The study adopted a ‘deductive’ approach to the thematic analysis for coding and analysis. A predefined set of codes, named anchor codes, was taken from the research question and assigned to the dataset in order to analyse interesting themes and to ensure the mental health aspects of the study were

coded (Appendix 11). These predefined codes ensure that all-important themes are identified and reduce the bias of proving the hypothesis. The coding and analysis at this point was at the semantic level in order to identify patterns in what the Christian leaders said about their experiences and management of the mental health issues of congregants.

5.2.2 Analysis

At this initial stage, the researcher familiarised himself with the raw data by reading the agreed flip-chart summary, personal notes and some transcripts of audiotape of discussions, noting initial thoughts, ideas, emerging themes, and exciting features. The typed agreed summary notes were reviewed and read alongside the audiotape to check for accuracy, to facilitate immersion into the dataset and to make sense of various answers, thereby enabling the process of coding and identifying key themes (Appendix 11 &11a).

The second step was to generate initial codes using the deductive coding process. The coding was conducted manually using a Microsoft word document. Adu (2019) suggested a six-step process when coding using a word document. These are:

1. Anchor code one - assign labels to the research question
2. Anchor code two - code relevant statements and put them under their respective headings
3. Anchor code three - compile a list of initial codes
4. Anchor code four - group codes into their separate anchor codes and arrange them alphabetically
5. Anchor code five - group codes under each anchor code and tally frequency
6. Anchor code 6 - generate categories/themes to address the research/evaluation questions (Adu, 2007; 2019, p. 89).

Kane and Trochim (2007) suggest having a ‘focus prompt’ related to the research question to guide the generated codes and represent relevant information in the dataset. Five anchor codes are directly taken from the research question to identify relevant information from the data. The anchor

codes are labels to provide focal prompts to recall important information from the dataset. The anchor codes used are (1) Better Equipped; (2) Training Needs; (3) Members with Mental Health Issues; (4) Church and Mental Health; and (5) Spiritual and Pastoral care. The initial codes generated roughly 547 codes in total. More detail on this process is outlined in Appendices 11-16.

The third step is searching for themes/categories. Miles and Huberman (1994, p. 69) suggest that themes emerge as a result of gathering the codes into smaller sets, according to their relevance and placing similar codes into categories to reflect and to suit the analysis. The researcher defined those code features that reoccurred several times in the dataset as themes to encapsulate participants' experience with their congregants. The frequency of a code highlighted the importance of the themes and ideas in the dataset. In this study, the researcher listed unique words according to the number of times they occurred in the dataset. The codes were gathered into categories to detect the overarching theme that captured the story of the participants. The researcher considered Emerson, Fretz, and Shaw (1995) who suggest,

> aside from frequency, the themes developed and selected for analysis are those that resonate with the research question (cited in Saldana 2009, p. 143).

The fourth step is revising the themes for consistency. In this step, the researcher reassessed those themes without sufficient codes and their viability as themes. The researcher incorporated these to create unified themes as their codes shared a similar meaning. To form a coherent pattern within each theme, the researcher reread all codes and themes and compared them with the raw dataset to create a comprehensive, cohesive narrative of the experiences of the participants.

The fifth step involved refining and naming the themes that corresponded to the research question. Braun and Clarke (2006) suggest the process of defining and refining themes to capture the essence of each category, ensuring they are relevant and cohere with the participant narrative.

5:3 Findings

Through the process of coding, the researcher breaks down the larger dataset, converts them into smaller and a more manageable codes and by examining the differences and similarities, converts and reduces the codes into themes. The researcher created 547 codes from the dataset using Microsoft word as discussed above and condensed these into meaningful main themes to address the research question. The themes were arrived at through the processes discussed in steps 4 and 5 of section 5.2.2. A summary of the findings within the main fifteen themes is presented individually and illustrated by extracts from the dataset. The results highlight and incorporate relevant participant contribution, for example, quotes that were unusual, interesting, or important in addressing the research questions (see Appendices 14-16). The findings suggest that:

1. Christian leaders lack resources and the resources provided are not adequate.
2. They feel out of their depth when working with congregants – and struggle to 'pastor'.
3. Prayer seems to fail them.
4. There is an unhelpful theology of mental health illness: demonic causes, faithlessness etc.
5. There are negative attitudes towards mental health.
6. They feel they need to understand the field of mental health - roles and language.
7. They wish to create partnerships with mental health services and be conversant with referral pathways.

The researcher grouped the findings into three main themes discussed under the summary of findings in section 5.3.2. The researcher interrogated the themes within the existing literature and examines them in greater detail in Chapter 6, using Bourdieu's concept of habitus, cultural capital and field to

understand how status, authority prestige and privilege impact on Christian leaders in the mental health field of the NHS.

5.3.1 Participant feedback

The participant feedback meeting outlined the findings of the research and explored whether the findings resonated with the two inquiry groups, as discussed earlier (Chapter 3, p. 60). Birt *et al.* (2016) suggests that studies undertaken to understand experiences and behaviours and to potentially transform practice should offer participants the opportunity to see their experiences and comments reflected within the final results. Lincoln and Guba (1985) suggest that feedback from participants is a process that enhances rigour and provides credibility of the study. It offers participants the opportunity to influence the analysis, giving them permission to agree or disagree with the findings (Birt *et al.*, 2016). The iterative process of cooperative inquiry reflection; the ongoing systematic cycles of self-reflection and critique; and the agreed flip-chart summaries as validity processes may be a reason for not undertaking member checking (Morse, 2015, cited in Birt *et al.*, 2016). However, in this study, as already agreed (Chapter 3) it was vital for participants to see their shared experiences within the final results.

The feedback provided a level of consistency and dependability in the findings and checked that the researcher's presented account corresponds with what participants said during the inquiry process (Thomas, 2016). The most popular method used for seeking feedback is by sending the summary findings to participants for review (Goldblatt, Karnieli-Miller, and Neumann, 2011; Pazokian, Zagheri, Tafreshi, and Rassouli, 2014, cited in Thomas, 2016). The researcher therefore sent a written summary of emerging themes for participants to review (Creswell & Miller, 2000).

The researcher emailed the participant groups detailing the stages of coding and the emerging themes with individual explanatory quotes, requesting comments on whether the results resonated with their experiences, and also proposed a date for a final meeting to review the findings for accuracy. A

primary concern was for participants to see me not as the 'expert', accepting the researcher's interpretation and representation of the data, but for participants to fully engage with the feedback process. Estroff (1995) cautions with regard to the researcher's status and how participants might view the researcher as 'privileged'. He recommends doing all to avoid a tokenistic involvement of participants (cited in Birt *et al.*, 2016). I suggested a format for the feedback, used for member-checking and taken from Birt *et al.* (2016), namely that the discussion should follow this process:

- Do these themes resonate with you?
- Do these findings match your experience?
- Would you like to add or change anything?
- Please note I would like us to discuss Yes or No answers.

Comprehensive feedback from Southeast 1 and 2 in Appendices 17 and 18 has been included. In this section, I briefly reflect on the input from Southeast 2. Southeast 2 'cooperative inquiry' convened a face-to-face meeting to review the research findings on 25 June 2018, seventeen months after the last meeting. Seven of the Christian leaders were present, two sent their apologies, and one joined via a conference call.

Before the meeting started the participants stated that they had gained significant insight into their experience and said that the inquiry group had changed their perspective on mental health issues. The richness of the debates on the shared stories had helped them to see things differently. The Christian leaders now viewed mental health situations with care, although still struggled to offer answers to specific problems.

Overall, Christian leaders agreed with the themes and findings. Jo and June (pseudonyms) said,

> I like your findings; they express and capture our discussion and have reflected on the conversation we had here very well.

However, Jacob felt that the power of God was missing, stating that it was necessary to include God, prayer, and healing as they are vital features of the Christian community.

5:3.2 Summary of Findings (Appendix 15)

The themes generated by the inquiry groups are as below:

Concerns about good and effective practice

This theme relates to how the ministers envisaged the best pastoral care for members with mental health issues. All the Christian ministers said that pastoral care is an integral part of their daily responsibility to the church - they are called by their religious communities and accredited through professional training and ordained to provide this ministry. Several ministers acknowledged having personal experience responding to church members with emotional problems. However, the mental health issues of congregants they encounter are more complex and demand extra or expert support – either from church members with the correct knowledge, or mental health agencies. One participant identified the lack of resources as one reason why ministers are left feeling out of their depth,

> Clergy lack resources and resources provided are not adequate, leaving us out of our depth especially when we are trying to deal with a multitude of different people with mental health issues situations (Angelina).

Some participants felt that mental health provision for the clergy was weak. However, one participant, a mental health awareness trainer for Christian ministers, said that the mental health training provided was adequate, although other participants disagreed.

1. Collaboration with mental health services

All the participants acknowledged that working with mental health agencies would reduce the stress involved in managing church members with mental issues. Some participants felt that mental health professionals are suspicious

of the church. One participant from Southeast 2 said mental health services would not welcome some practices of the church as they are oblivious to the spiritual dimension of mental health problems, and such negative attitudes towards religion would hinder collaboration. Participants said chaplaincy services could help but they did not want to take advantage of their service,

> I have thought of doing that, but don't want to take advantage, being on the course. Is it overstepping the mark? Linking in with local mental health chaplaincy service would be hugely beneficial (Angelina).

Referral to services

Participants agreed that although they are better placed to refer their congregant to mental health services, they are less confident in doing so. Most participants were reluctant to engage with the mental health service because they are either not knowledgeable about how referrals work or are unable to communicate their reasons for referring a congregant. The participants felt that linking their churches to local mental health professionals or teams for consultation would encourage early referrals and necessary intervention.

Barriers to access

Christian leaders saw negative attitudes from mental health professionals as barriers, preventing them from engaging with the mental health service. One participant, Blessing, informed the group about a congregant who had said psychiatrists are less interested in the religious aspect of mental health issues, so they are not confident in discussing their religious problems with them. The participants were intimidated by the negative and sometimes anti-religious messages from psychiatrists, saying that they 'did not listen' and 'were not interested' in the faith response. The challenges or barriers to seeking help are due to religious stigma and often prevented church members from seeking professional help. The participants proposed openness and acceptance of mental health challenges to help reduce religious stigma and normalise mental health issues in the church.

Medical versus the spiritual

The participants felt that dealing with mental health problems had become a significant part of their work but that this had been thrust upon them and they were not well prepared for it. They agreed that the mental health dimension of their role in listening to stories of members with issues was complicated and confusing. Angelina commented on this complication with the example below,

> This requires more than listening; I am a little bit stuck with what else to do: I don't know what I need to be honest with you, that is the honest truth. Among the several different things we are dealing with; in some cases, I am out of my depth. I can deal with people with addictive behaviour, other people with addictive behaviour seem to be OK, but with this person, I don't know what else to do … such a person belongs to a psychiatric hospital and not the church.

Participants were not sure how to respond to Angelina's example. However, they would have liked to know more about her care. Angelina reflected that if you took out everyone with some mental health issues from her church, the membership would decrease by a third. However, the participants felt that this person would be better supported with some background knowledge of the difficulties of the condition, behaviour, medication or possibly of being admitted to hospital if their condition gets worse.

A participant (Jacob) from Southeast 2 said,

> The mental health practitioners were academic rather than spiritual; this is because many psychiatrists see religious beliefs and practices as illness.

Participants asked Jacob to explain what he meant by 'academic'. He said,

> Mental health practitioners have no spiritual, practical relevance, they are mostly theoretical. My congregant tells me psychiatric

> professionals have a negative view on cases with spiritual and religious content.

Other participants, for example Venette, felt that not all mental health practitioners emphasise the 'academic', but Jo thought it was showing-off, a reference to being in charge. I asked the Christian leaders for clarification as to what they meant by 'reference'. June replied,

> It is their way of seeing things. However, they cannot diagnose demon possession, and neither do they have the 'spiritual gift and discernment' to distinguish between the 'physical health' and 'spiritual health'.

Some participants felt that 'demon possession' was real and not to be dismissed as we live in the spiritual world, so needed knowledge of mental health issues to help them make the distinction. Lalita said that pastors do not diagnose and any attribution to the manifestation of demons is ignorance. The demonic thinking distorts what support to give to congregants with mental health problems.

Southeast 1 did not deliberate on demonic causation until the researcher asked the group about it as it was a training issue in Southeast 2. Emilia said,

> Mental illness is not mentioned in the Bible. Is it because some of it was picked up as demon possession?

As a result, I asked the group about what they thought of mental illness as demonic possession. Is the church running away from its understanding of mental illness as demon possession, or have we misunderstood the church in this regard? And why are some pastors saying it is demonic instead of mental illness? This is an example of where I became a participant as well as a researcher.

Angelina said, "I have seen and experienced it". She explained that it was too simplistic to say congregants were demon-possessed as people will run away if demon-possessed, and to be fair every diocese has an exorcist although they

do not call it that. Angelina seemed to justify the existence of an exorcist for minor spiritual issues such as home cleansing. For example, a congregant from her church asked for their home to be cleansed from evil spirits inhabiting it as they were terrified. The congregant invited Angelina to say prayers to get rid of these 'spirits' at the house.

> Bringing the big guns coming around, after praying, they never heard these spirits anymore (Angelina).

All participants agreed that demonic issues were problematic for some Christians. They agreed that there is a consistent belief in the powers of demons but how much that is related to mental health is not clearly defined in the church, which leaves leaders and members guessing. Olu exclaimed "It would be a big step forward for the church" if they had trained church members and pastors in mental health issues.

Jacob reported that mental health professionals were not interested in spiritual interpretations, "That's why they label people straight away, especially when you declare that you heard voices in your head." He said there are spiritual ways of understanding people who hears voices, and not everyone who hears voices is mentally ill, "Is it, Josiah?" "I don't know" I said, "Let us explore this together, shall we?"

Jo and Lalita suggested the use of animal or 'pet' instincts to pick up on unseen reality, things that are there but which cannot be explained and cannot be described. By 'pet' instinct, they meant that animals could help with the unseen issues people present. During this discussion I said that it is difficult to imagine a pastor in the office, with a member having mental health issues, waiting for a diagnostic prompt from a dog (Josiah).

The participants group from Southeast 2 used the language of the Bible in discussions and talked about discernment to explain the unseen part of mental health presentation. They spoke of different levels of discernment built on spiritual knowledge to distinguish good and evil. Both inquiry groups thought

that they would find it helpful if they could identify the differences between spiritual experiences and mental distress.

The group summary reflection was that there is the manifestation of demonic possession/release alongside reasonable psychological explanations. However, very often the latter is a preferred explanatory model.

Understanding mental health issues

The Christian leaders asked what they could do to equip their practice better, and how they could communicate their understanding so that church members with mental health issues feel safe and supported. The participants said they just 'know' if a congregant is ill, as they see that something is wrong but cannot tell whether there has been a diagnosis or not. Participants said they did not wish to inquire further because of lack of resources, and they had felt out of their depth when they had intervened in the past.

Both participant groups felt strongly that resources are weak, especially,

> when we are trying to deal with a multitude of different situations, including people with mental health issues (Venetta).

Angelina then commented on the weak resources as below,

> So, if we are dealing with people with a certain mental illness, it is about learning again, the resources aren't there. Learning about as much as possible to enable us to understand a bit more, so then we understand more about the listening and identify the issues that matter.

Emilia put it like this,

> I am not getting what I need, and all the courses on mental health I did was by my initiative because there was a need in my congregation. I did them outside my dioceses and in addition to my theological training. We are not getting the support, and the church overall is not paying attention to mental health well-being of their clergy and congregants. Does that make sense?

Southeast 2 suggested training in mental health first aid for Christian ministers and congregations. This training programme would be for church members and their ministers to act as capable first responders in mental health crises (Mental Health First Aid, 2013).

Theology and mental health

Theological debate on mental health issues was not openly discussed or reflected, on as participants agreed from the outset that they did not want to be distracted - a theological conversation on mental issues can become difficult and complicated. However, in some instances participants alluded to theological themes, such as the role of God, in mental health problems.

Olu asked, "What does a theology of mental health look like?" There was a preliminary discussion on what some referred to as 'more hands-on theology' as experiential training is more than theoretical. The Christian leaders did not agree to a unique theological concept of mental health issues.

June was critical of theology and teaching from some Christian quarters which saw divine healing and prayers alone as a remedy for illnesses as damaging. Emilia's experience with a church during a mental breakdown episode emphasised June's concern. She narrated how she felt let down by her church as its answer to June's problems was to offer prayers of healing. The healing never happened. June said, "They moved to provide answers – prayers and all that nonsense". (She appeared too angry. So, she had to leave that church) "But what is healing? Not in that way..."

The Christian leaders reflected on how a quick explanation is likely to make people feel worse for not being able to be 'fixed'. A more helpful approach is to offer support that honours people's struggle. Upon the reflections of the experiences shared by the participants both Southeast 1 and 2 concluded that some religious practices were helpful, and some unhelpful.

Unhelpful theology

Participants reflected that church members with mental health problems often reported that there was something supernatural happening to them and struggled to unravel the superstitions and misunderstanding around mental health issues. For example, Abby shared a situation where he refused to pray for a distressed young person because he heard the voice of Satan.

The elders wanted Abby to exorcise this person for demonic possession. Instead, Abby advised him to go to A&E for assessment. The elders were uncomfortable with the advice, and felt Abby was losing his faith. Abby said although he believed that prayer was essential, at the time he thought that it was not appropriate to say open extempore prayers. In retrospect he felt that prayers were necessary for this person because it would not harm him and would continue to pray even if the issues remained. Unhelpful theology consisted of a pastoral intervention that uses religious language and spiritual explanation that creates anxiety, or that is unhelpful for congregants.

Healthcare practitioner theology

Participants thought that a more comprehensive provision and advice on theological explanation through chaplaincy support should be made available for the pastors. Both participant groups noted that church members with mental health issues are now common. The lack of adequate community care may explain why members are seeking help from the church. However, the priority for Christian ministers is a need to find a way of articulating how they offer pastoral care.

The group struggled to find a common language for explaining views on mental health issues. The participants were united on the fact that they are not mental healthcare practitioners, but they felt that understanding the problems their members face will better equip their pastoral practice. This will require them to develop an exceptional understanding, to strengthen the knowledge and skills needed to address mental health issues presented in their churches. The chaplains in both inquiry groups also needed to engage more strongly

with congregation members with mental health issues, due to their clinical pastoral training.

Attitudes

Angelina described a person who had verbally attacked church members, and that this openly-displayed aggressive behaviour had affected other groups in the church. She reported that this person would follow church members around the town centre shouting obscenities at them, and this behaviour drove people away from the church. One of the church members had actually moved to another town as a result. She said,

> This congregant's behaviour is too erratic; I felt less equipped and needs more than my listening strategies; they are not enough. Practically what do you need? Call the police! Pastors require the assistance of the police to help with members of congregation needing psychiatric help. I can pastorally support by listening to her, challenging her, using all pastoral strategies. I have exhausted all my skill to help, and I don't know what else to do. Some members of my congregation would run away from her because they need a rest from ongoing verbal abuse. I have seen her doing this to other congregants, (Angelina said laughingly). This congregant would stop and approach me with smiles, she does not want me to see her in the bad light; with this one, I am a little bit stuck with what else to do. What do you do with this complicated congregant; we all do want to help, but how?

Angelina articulated a fear of perceived violence associated with mental illness. This view affected and inhibited her willingness to engage with such a congregant. The participants agreed that such behaviours had a negative bearing on their attitude towards the mentally ill and recognised how such attitudes affected the congregation. Although the Christian leaders had had varied experiences supporting congregants with mental health issues, attitudes to such aggressive behaviour have always been complicated, challenging and harmful. Attitudes such as the one discussed above contribute to the religious stigmatisation of congregants. Undesirable, mysterious, risky,

and threatening behaviour, and the uncertainty surrounding this congregant created a frightening perception for church members. The sufferer was not able to communicate their problems and was therefore perceived as volatile and dangerous. According to Gray (2001), media depiction has also strongly associated violence with mental illness. So, the Christian leaders may have some concerns about danger and volatility. This example raises the question of Christian leaders' level of 'toughness' with congregants with a significant mental health issue.

Leavey, Loewenthal, and King (2007) commented that Christian leaders are helpless, as the church cannot be harsh with the marginalised or isolated. Such actions may be seen as "dissonant with the perceived or internally cultivated caring image and values of the church" (Leavey, Loewenthal, & King, 2007, p. 554).

Pastoral skills needed in mental health care

The participants felt that their duties as church leaders are complex and have different expectations, whereas a pastoral role needs to be clearly defined. They felt that they are priests before God to lead the people in worship and to help their congregation to relate to God through teaching, instruction, the guidance of the Bible, and through supporting people in their religious life. We had difficulty in defining pastoral care, and particularly how we saw our role with people with mental health problems in the congregation. Angelina commented,

> There is much talk about it; pastoral work has more to do with numbers and growth and keeping, like the Romans in the first century. So, if everything is going on nicely, then pastoral care, coffee, and chats, but when there are problems, it takes the easier route.

Angelina felt her church has a misplaced priority and focuses on the numerical growth of the church rather than caring. June's point of view was that pastoral care is about practical application, personal devotion, Godly touch, compassion, empathy, listening skills, the theology of 'giving hope',

and the courage to go against beliefs, upbringing, and training in favour of benefit to church members.

Time-consuming

The ministers showed a degree of ambivalence about getting involved with acute mental illness as they felt previous involvements had strained time and resources. They did not have enough cultural capital to enable such participation. “We simply had no mental illness training, and therefore, we feel less equipped” (Emily and Olu).

Abuse

Christian leaders from Southeast 1 discussed aspects of pastoral interventions that could be misconstrued as abuse, as they thought miraculous healing, or a supernatural intervention could cause vulnerable congregants to be reliant on the supernatural. The Christian leaders thought an emphasis on the supernatural may cause congregants to stop taking medication or following their treatment plan and may become doubtful of their faith when the ‘miracle’ fails. Emilia commented that although God has not stopped working miracles, it is difficult for her to rely on the supernatural as a possible pastoral intervention. She told the group that a miracle did not happen for her, however God works in different ways. The participants concluded that the tension between congregants seeking help from psychiatry as well as the supernatural would have to be carefully managed.

Lack of knowledge

> I don’t feel equipped to deal with this situation. It needs more than me, practically, some back up to deal with this because what I am doing now is not working (Angelina).

Some insightful stories shared by the participants added depth to the findings. June shared her mental health issues with the participants,

> For me, I suffered from chronic burn out, and I got to the point where my head was spinning and disconnected from my heart. As a

> chaplain and a manager, I wasn't cared for, nor supported by my faith group. I lost the ability to have emotion, so I was fully broken. In the six months of not knowing, I learnt about presence ministry, which is living with people. I come from the place of experience. So, I listen. As a chaplain working with homeless people, once two people who wanted to kill themselves came to see me; I listened to them. My focus on mental health is because I have lived through it, and my vocation is the power of listening. I can't fix them but could help with all the practical stuff.

When the other participants reflected on this some suggested counselling and psychoanalysis. Erica said, "I will try to find out where this is coming from, and if you don't deal with it from the core, it will always come back." But other participants were interested in a pastoral response. Most participants thought they would encourage referring on to professional help, while others thought they would not be involved in something they do not feel equipped to handle. "Not my area, so would refer the person and offer pastoral care at the same time" (Olu).

5:3.3 Summary of themes

The themes show that the Christian leaders in this study find themselves front-line mental health pastors for congregants with mental health issues. These themes highlight their struggles to engage with and understand the mental health needs of congregants. The responses of the Christian leaders are varied, ranging from doing their best in the circumstances to not being able to articulate the nature of their task in a way that is meaningful to either their congregants, or the National Health Service that cares for them. The themes indicate that congregants have confidence in Christian leaders, but they cannot demonstrate the practice of theology in the lives of their distressed congregant. The discussion on theological engagement with congregants' experience within the mental health field would be in Chapter 7.

Having discussed the findings, this leads me to the second level of examining analysis, which is the application of Bourdieu's framework as discussed in

Chapter 4. This will interrogate the themes obtained from the researcher's thematic analysis of the dataset.

5:4 Applying the theoretical framework of Bourdieu's concept of habitus, cultural capital and field to understand the emerging themes

Following the thematic coding, I then conducted the second stage of analysis using Bourdieu's (1977, 1986) concept of field, cultural capital, and habitus to reveal the latent findings underlining the themes from the thematic analysis. At the latent level, the analysis goes beyond the semantic scope to identify the underlying ideas, assumptions, and conceptualisations theorised as shaping or informing the data's semantic content (Braun & Clarke, 2006, p. 85). This second phase of the analysis gave an in-depth interpretation of the themes. It synthesised the themes from the thematic analysis to convey the changes in Christian leaders' durable disposition to reveal their capacity or cultural capital in the professional field. Juxtaposing the two fields reveals their cultural capital's capacity and influences each other's position within the mental health field.

As discussed in Chapter 4, the mental health field structure consists of power relations forced on those entering the field. Bourdieu stated that the field, therefore, is "not reducible to the intentions of individual agents or even to direct interventions between agents" (Bourdieu, 1991b, p. 230, cited in Doblytė 2019, p. 275). In such a structure, the Christian leaders cannot act independently by their religious logic but are constrained by the historic determined structures and rules of the professionals' actions within the treatment system. The mental health institution structure and durable rules embodied in the mental health professionals' habitus and the power relations between the Christian leaders and mental health professional determined the supports given to congregants.

In this second phase analysis, the emergent themes were viewed to compare the effectiveness of cultural capital of the religious field related to the clinical field of the mental health professionals in the NHS. I paid attention to habitus and cultural capital changes because they convey durable changes in

dispositions and capacities in the mental health field. Bourdieu's framework highlights the relational qualities of how the Christian leaders are caught up in the cultural capital of mental health professional habitus where status, prestige, and privileges, and the mental health field's reputation, denied them their contribution to the care of congregants. The effect of the changes and differences in the habitus and cultural capital of Christian leaders and mental health professional showed that Christian leaders are isolated and denied a voice in the field of mental health professionals. The conflict created because of variations in Christian leaders and clinical professionals' habitus and cultural capital, the power, reputation, and status of the clinical professional's dominance inadvertently isolated the Christian leaders, leaving them silenced.

Secondly, I applied Bourdieu's concept of cultural capital to the theme 'effective practice' to determine the efficiency of the faith response. Cultural capital of Christian leaders, for example, does not count much in the mental health field, leading some mental health practitioners to question the Christian leaders' ability to address the mental health concerns of congregants. The cultural capital of faith does not matter much in the professional field, and the readiness to collaborate in the field of mental health care has affected the willingness to engage, leaving Christian leaders less noticed or even ignored. The impact of being ignored leaves the Christian leader doubting the appropriateness of the support given to congregants, creating a sense of getting it wrong when supporting congregants with significant distress at a clinical level (Leavey & King, 2007). For the Christian leaders in the mental health field, learning then involved developing their habitus to operate in the mental health field of the NHS efficaciously. As noted by Schatzki (2017, p. 29, cited in Aitken *et al.,* 2019) "the more the habitus is acquired, the better someone can proceed in these fields and a greater range of situations." The Bourdieusian concepts reveal the interaction of the NHS culture and its approach to understand how power, prestige, authority, and status in the mental health field impact on Christian leaders and congregants. Bourdieu's theory provided further insight into the interactions of the Christian leaders'

subjective experience in the structure of the mental health field of the NHS and interpreted significance patterns to offer broader meanings and implications (Patton, 1990).

Thirdly, I examine Christian leaders' efficiency of faith response and pastoral skills to determine how power and conflict between mental health professionals disadvantage Christian leaders in practice. The mental health professionals who occupy the prestigious position suggest that professionals kept a social distance between Christian leaders and themselves to observe the field's hierarchies. The social distance between the two different but unique practices denies the recognition of the faith response. The power of cultural capital and the habitus, which are the production, practices and structures of mental health professional are recognised as legitimate in the mental health field due to the volume of cultural capital they possessed. The Christian leaders' pastoral skills are less recognised and are disadvantaged due to the lack of legitimacy of faith responses to congregants' mental health needs.

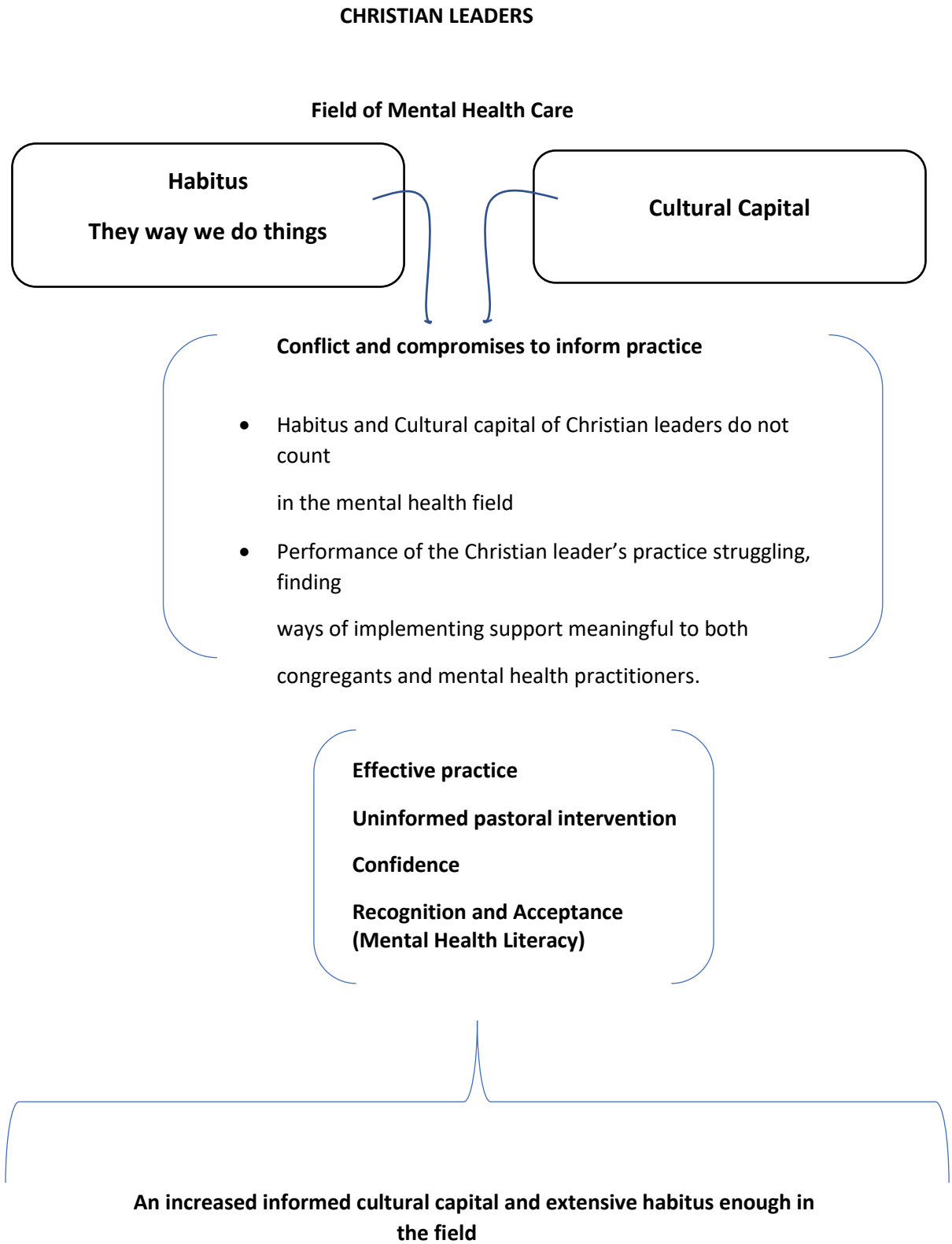
Finally, I examined the language Christian leaders used to explain mental health problems, for example demon possession and not having enough faith, categorised as unhelpful theology. According to Mercer (2013, p. 606) demons have no place in the conventional understanding of mental health problems or treatments, even if a congregant's religious belief is essential for successful treatment, and deliverance prayers are implausible and incongruent with traditional assumptions about mental illness. I interrogated this position by asking what Christian leaders should know to operate in a way acceptable in the mental health field (Goodenough, 1976). To answer this question, I apply Bourdieu concept of language as a form of capital that either empowers or disempowers depending on its relation to other forms of capital in a given field (Bourdieu, 1997, p. 99). For Bourdieu, language is a kind of wealth, which all field agents can use without causing diminution. Therefore, Christian leaders' cognitive structures should reflect the structural position of professionals in the mental health field to access the powerful tool

of mental health literacy to enable to operate and support congregants (Hurley et al., 2020).

The habitus of Christian leaders, the embodiment of their religious culture predisposes them to think and speak in particular ways that were not conducive to the mental health field. This embodiment includes religious language; however, if Christian leaders' linguistic habitus is congruent with the mental health field practices, they have greater access to the field; therefore, mental health literacy will give Christian leaders greater access.

I have created Figure 3 from my understanding gained from reading Bourdieu's concepts to capture the latent analysis as discussed.

Figure 3


CHRISTIAN LEADERS
Field of Mental Health Care
Habitus
They way we do things
Cultural Capital
Conflict and compromises to inform practice
• Habitus and Cultural capital of Christian leaders do not count
in the mental health field
• Performance of the Christian leader's practice struggling, finding
ways of implementing support meaningful to both
congregants and mental health practitioners.
Effective practice
Uninformed pastoral intervention
Confidence
Recognition and Acceptance
(Mental Health Literacy)
An increased informed cultural capital and extensive habitus enough in the field

The application of Bourdieu's concepts suggests that Christian leaders struggle to care for congregants with mental health issues due to inadequate relevant mental health-related cultural capital. This inadequacy has caused the mental health field professional to question the preparedness and the legitimacy of the faith response, leaving Christian leaders isolated in the care of the congregants. The four main categories for discussion are from an amalgamation of the findings of Southeast 1 and 2, using Bourdieusian concepts of habitus, cultural capital and field to interrogate the themes (see Appendix 19). These categories are:

- Helping the unwilling to become willing (participant change)
- The legitimacy of faith responses to mental health
- The silencing of the faith response
- Mental health literacy

Chapter 6 Discussion

6:1 Discussion

Following the analysis in Chapter 5, a summary of the findings is presented and discussed here. This chapter will discuss the significance of the results, how they relate to the research purpose, sense-making, and challenges within the broader literature. Chapter 7 will then focus on the broader theological implications of the study and its implications for a curriculum for Christian leaders.

6:2 Summary of findings

My findings suggest that even though Christian leaders have a willingness to engage in the care of congregants with mental health issues, they feel silenced by questions about the legitimacy of the care they provide. Christian leaders feel their work with congregants is not respected, and contributions are not given significant value. The significant pastoral role of Christian leaders is less recognised, questioning the acceptability of faith response. Therefore, the Christian leaders require literacy in mental health to better support congregants.

6:2.1 Willingness to engage

During our discussions, participants explored why they felt they struggled with congregants with mental health issues, compared to other congregants. Christian leaders indicated some overall knowledge about mental health, however ninety per cent stated that they had no training in mental health; and only ten per cent some training in pastoral counselling. Of those who had experienced training, June suggested that the mental health training during the seminary period was only an introduction. Participants who had training in counselling skills said that they had found this useful, but that it did not adequately prepare them to meet the challenges of congregants in the care of the NHS. The consensus of the group was that members felt unqualified, their skills had been ineffective in the past and they found their lack of expertise challenging when supporting congregants.

Researchers (Leavey *et al.,* 2011; Payne, 2013; Wood, Watson, & Hayter, 2011) highlight that Christian leaders struggle to engage with congregants with mental problems without proper training. This lack of mental health training gives rise to tension between the biblical approaches and NHS mental health services' expectations. The methods used to support congregants by both Christian leaders and mental health professionals suggest possible conflict, given the suspicions and mistrust that exist between the mental health and religious fields (see Chapter 4). Neighbors *et al.* (1998, 1999, cited in Sullivan *et al.,* 2013) hold the view that different approaches to healing within Christian communities can impact on the way a congregant seeks psychiatric help, and possibly increase tension and mistrust between the clergy and healthcare providers. A congregant seeking help starts with how the individual understands and conceptualises mental health issues, which are often influenced by their religious experience and beliefs system. Congregants may be affected by explanations of these issues as a supernatural phenomenon caused by demonic possession, or a weakness in one's faith which can be overcome or cured through divine intervention (Leavey, Loewenthal & king, 2007).

Jacob (a participant) suggested that the power of God was significant when dealing with the mental health problems of congregants. Studies find that some congregants rely on divine intervention (Cornah, 2006) and consult their priest in the fear that a psychiatrist may be dismissive or pathologise their religious experience (Fulford & Jackson, 1997; Verhagen, 2017).

Christian leaders said congregants state that their religious beliefs were important to them during a mental crisis but felt inhibited when discussing such concerns with their psychiatrists. Culliford (2007) and Forrester-Jones *et al.* (2017) suggest that many religious people using health services would choose to have their spirituality and religion addressed during their treatment. However, religious and spiritual needs assessments are not discussed or included in care and treatment planning (Vieten *et al.,* 2013).

Similarly, the emphases of the medical model or culture of care, dominated by a medicalised approach (Morgan, 2017), dismiss the value of the pastors' intervention, who are therefore reluctant to collaborate or refer congregants to mental health services. Sullivan *et al.* (2013) notes that those Christian leaders who are inclined to disregard or demonise the medical model run the risk of delaying or blocking access to available mental health resources for their congregants. Verghese (2008) points out that the religious needs of congregants are now widely accepted in the mental health field. However, Cook (2011) draws attention to the fact that faith and spiritual issues remain in conflict with psychiatry in the light of hostile mental health professionals, and Sims (2003, 2009) also noted the existing mutual suspicion between Christian leaders and psychiatry; and the past anti-cleric stance of psychiatry as contributing to such hostilities. These negative assumptions have affected any decisive role that Christian leaders may play in the treatment of the severe mental illness of their congregants or engaging with treatment services in the NHS. Therefore, not many psychiatrists make use of religion and spirituality in their clinics (Verghese, 2008).

Christian leaders said they would find it more helpful if they had training in psychological approaches when supporting congregants. Other participants with training in counselling found the skills from counselling useful in listening but needed more than this. Among the participants, Olu stated that listening was an essential contribution church ministers offered in helping people with mental health issues. Angelina, however, commented that sometimes pastoral encounters required more than listening. She often found listening to congregants challenging, and worried about saying the right thing, or asking the right question. Morrissey and Callaghan (2011) draw attention to listening as an essential but challenging skill in nursing care. The Christian leaders had often found themselves out of their depth, regardless of best intentions. Although they felt better equipped when listening, some doubted best practice when talking about what had helped congregants with mental health issues. However, most participants agreed with Angelina that Christian leaders are pastors first, not trained clinical psychologists or mental

healthcare coordinators, and therefore cannot provide the same expertise as a mental health professional.

Christian leaders have many years of experience working with congregants with mental health issues and have accumulated pastoral knowledge and expertise. Despite this apparent positive contribution, the positive relationship between religion and mental illness, and their willingness to engage with mental health services, they find their listening skills inadequate and feel ill-equipped to engage with congregants with mental problems, or with the NHS.

Dein *et al.* (2010) argue that Christian leaders are more likely to be involved with congregants presenting with mental health issues, as many psychiatrists working within the medical field feel less competent to address spiritual problems in their clinics. Jacob, one of the participants, as discussed in Chapter 5 highlights the congregants' unwillingness to engage with psychiatric services. Koenig (2001a) suggests that congregants choose not to disclose their religious stance or issues for fear of being branded delusional.

It is in this light that Dein *et al.* (2010) suggest a need for more understanding of religious belief in the mental health care of religious patients. Jacob (participant) refers to the medical field as "academic and scientific" (see Chapter 5, pp. 99 - 100) and emphasises the over-representation of the medical model in denying the recognition of the religious input. The value placed on the status, power and authority of psychiatry and their relevant cultural capital dismisses the legitimacy and efficiency of the religious field, discouraging Christian leaders' willingness to engage with the mental health field when caring for congregants.

6:2.2 The legitimacy of the faith response to mental health

Christian leaders reported that the medical field struggles to accept the legitimacy of the pastoral intervention of the religious field. The concerns of congregants and Christian leaders were either ignored or rejected, not recognised as within the scope of psychiatry, or met with the strongest disapproval and seen as a harmful and neurotic illness (Cook, Powell, & Sims,

2009; Koenig, 2007). Regardless of the question raised on the legitimacy of the Christian leaders' response, Erica offered her perspective to provide the significance of the pastoral support of Christian leaders when she said,

> We respond well to the needs of members coming to us for healing prayers and spiritual direction with disturbing personal and emotional issues. "We are the converted", and we have some helpful tools, skills, and knowledge which we have acquired through the introduction course (Erica, Appendix 11).

Christian leaders play a significant role in the mental health care of congregants (Chalfant *et al.,* 1990; Veroff *et al.,* 1981, cited in Taylor *et al.,* 2000). Christian leaders respond and offer guidance on a wide range of personal and emotional difficulties of congregants and can function as gatekeepers to mental health services (VanderWaal *et al.,* 2011), helping congregants to access appropriate services (VanderWaal, Hernandez, & Sandman, 2012). The analysis revealed that the Christian leaders had no choice but to respond to members with mental problems irrespective of their mental health training needs; they were eager to attend pastorally to their congregants.

However, congregants have not always found this pastoral response to be supportive (Chalfant *et al.,* 1990). Cornah (2006) suggests that religious faith has been considered by some mental health professionals to be an active contributor to mental illness, contributing to existing barriers and constraints against effective partnerships between Christian leaders and mental health services. Because of this disagreement between the church and psychiatry, Sims (2009) suggested that congregants of Christian churches were often discouraged from engaging with psychiatry, even if congregants manifested clear signs of mental illness. Such uncertainty and distrust are observable in certain of today's churches, which can disrupt any form of partnership between psychiatrists and Christian leaders when caring for congregants (Huguelet & Koenig, 2009).

As the mental health field undermines the legitimacy of faith responses to the mental health needs of congregants, the Christian ministers reported pastorally caring for and advising many unwell or suicidal congregants. However, theological issues of how Christian leaders perceive the mental health issues of congregants may be unsafe and harmful (Leavey, Loewenthal & King, 2007) The Christian leaders examined their beliefs regarding the causes of mental health issues, and while the majority of the group demonstrated some understanding of the causes of mental illness, some demonstrated a belief in the role of demonic influence in mental illness. This view supports studies conducted by Leavey, Loewenthal & King, (2007) which looked at the attitudes to mental health of Rabbis, Christian ministers and Imans. This version of their reality conflicts with the causes and treatment of mental health issues in the NHS and isolates the practices of the religious field from the mental health field. However, as some congregants present Christian leaders with demonic problems, the two fields will need to explore the conflict that may arise in the interest of collaboration.

According to Harlow (2010), NHS England and Wales have no definitive standards to guide Trusts in setting up and running a service that supports Christian leaders in helping their congregants. However, NHS Trusts are mandated to respect congregants' religion and beliefs although there is little guidance as to how to achieve this. The religious field within the NHS field is therefore challenging to navigate for Christian leaders. More clarity around the provision of spiritual care is required (Mowat & Swinton, 2005; Swinton & Pattison, 2010, cited in Butler & Duffy, 2019).

Christian leaders understand that they are not mental health professionals or practitioners, and cannot be expected to behave as such. However, they offer a unique religious understanding that may be lacking in the mental health field. The Christian leaders discussed one congregant who had approached the pastor for deliverance through exorcism. Jacob said the psychiatrist could not "diagnose" demon possession, and neither do they have the "spiritual gift and discernment" to distinguish between physical health and spiritual health. Some participants felt that as we live in the spiritual world, demon possession

is a real spiritual phenomenon and therefore Christian leaders need knowledge of mental health issues to help them make the distinction. Other participants felt that attributing mental health issues to a demonic manifestation, and prescribing deliverance as a solution, is a sign of ignorance.

Other participants stated that an overemphasis of the demonic rationale for mental health issues could distort how they support people with mental health problems in church communities. All agreed that understanding demonic causation in mental health care is problematic for the church. There was no consistent view that demons caused mental health problems, however Jacob for example hoped that any new training for Christian leaders would recognise the impact of the demonic in mental health, which would help in supporting members going forward.

According to Leavey and King (2007), coincidental beliefs about the supernatural origins of illness may have profound implications for treatment. When it comes to exorcism, the relationship between the two fields becomes more complicated due to the sensitivity of the subject. The religious field interacts with the NHS and healthcare professionals who supply it with their model. Davey (2014) argues that in many cultures spirit possession is still a way of explaining mental trauma and other illnesses, as spirit possession causes unusual and unexplained behaviour. Hecker *et al.* state that,

> pathological spirit possession is a broad explanatory framework for various subjectively unexplainable mental and physical health problems, including but not limited to trauma-related disorders (Hecker *et al.*, 2016, p. 1).

They also suggest that understanding the demonic phenomenon of spirit possession as a subjective disease model for various psychological and physical health problems may help researchers and clinicians develop culturally sensitive treatment approaches for affected individuals (ibid, pp. 3-4).

Dura-Vila *et al.* (2011) suggest that working with both religious and medical beliefs about aetiology and the treatment of mental health issues may enable the care of congregants who are anxious about the cause of their suffering. However, Stanford (2007) suggests that explanations of mental disorder as weakness of faith, personal sin, or demonic influence causes congregants to avoid empirically validated treatments and reduces the chances for recovery, putting congregants at greater risk for suicide.

The religious field must interact with the mental health field, and these interactions are determined by how much cultural capital each one possesses. However, a medical habitus dominates the mental health field, leaving Christian leaders to struggle to be recognised as the balance of power no longer remains with the faith habitus. Those who have dominant field positions define the legitimacy of the faith response. Bourdieu asserts that the player's position within the social field corresponds to the volume of the different cultural capitals they have. To enable the Christian leaders to operate in the mental health field they need to improve or increase the authorised capital of the mental health field to allow a mutual acceptance for a collaborative partnership.

Christian leaders therefore need to be aware of how their own belief interacts with the structures and practices of the NHS, especially with regard to NHS safeguarding policies and systems (Safeguarding Policy: NHS England and NHS Improvement, 2019). Leavey, Loewenthal and King (2007) examine the barriers and dilemmas of clergy caring for people with mental illness from different faith communities, and reported on the scale and impact of the vital role played by Christian ministers. A further study by Leavey, Loewenthal and King (2007) considered how any future extension of clergy involvement in mental health should be suggested after thorough deliberation by both mental health services and religious organisations (ibid).

My analysis shows that participants feel they need to be medically trained, or have a degree in psychology, to feel accepted in the field of mental care, despite years of training in theology and ethics and accumulating wisdom

through pastoral practice. In light of this, Sutherland suggested that "neither pastor nor psychiatrist can function meaningfully without the other" (Sutherland, 1997, p. 18).

6:2.3 The silencing of the faith response

The findings indicated that Christian leaders have a willingness to engage in the care of congregants with mental health issues, but they feel silenced by questions about the legitimacy of the care they provide. Jacob clarified:

> Our views are not respected, and it feels like, as Christian leaders, we have nothing to contribute to the wellness of congregants.

The slightly cynical and sometimes anti-religious messages from the mental health field affect the confidence of Christian leaders caring for congregants (Curlin *et al.,* 2007). Jacob said although Christian leaders are not psychiatrists, the negative attitude of mental health professionals could render the care they offered insignificant, notwithstanding years of training and experience in pastoral care and the coping effect of religious belief on mental health (Huguelet & Mohr, 2009). The Christian leaders' concerns highlight Bhugra's (1997) suggestions that faith-based organisations' relationship with psychiatry has been characterised by mutual antagonism or suspicion. Such distrust contributes to the silencing of the faith response, and the existing mistrust and lack of confidence are likely to delay accessing appropriate care for congregants (Johnson & Westermeyer, 2000; Pargament & Saunders, 2007).

According to Farrell and Goebert (2008), poor collegiality between Christian leaders and mental health professionals has continually raised the question of the readiness of the Christian leaders to meaningfully engage in any proposed collaboration with mental health services. The dominance of mental health professionals in the mental health field (Kline, McMackin, & Lezotte, 2008), tensions caused by the church's abuse scandals (Dale & Alpert, 2007; Terry, 2008), and betrayal of church leaders have impacted negatively within broader secular communities. These tensions have severely affected the pastoral reputation of the church, creating hostility. It is, therefore, not

surprising that Christian pastors often remain silent about the experiences of congregants (Copsey, 1997), and have expressed concern that mental health specialists may undermine or show contempt for them.

Studies by Copsey (1997), Friedli (2000) and Koenig (2001b) on the relationship between spirituality and mental health make a case for collaboration between health care providers with faith-based organisations. However, the authority, status and privileges of the dominant voices overshadow the less powerful voices of the Christian leaders, leaving pastors feeling isolated. Leavey, Loewenthal, & King, (2007) argues that developing a collaborative relationship and attaining necessary recognition requires the proper training of Christian leaders. Leavey (2008) stated that Christian leaders could offer their congregants religious counselling to complement the work of mental health professionals, to improve recognition and be acknowledged as essential players in the mental health field.

In Bourdieusian terms, the spiritual or faith capital is silenced by the capital of professionals within the mental health field. The cultural capital of Christian leaders includes years of theological education, however the practical contributions, pastoral encounters and interventions in addressing mental issues have been silenced by the dominant cultural capital of the medicalised; and quietened by the tension within the broader secular communities. The Christian leaders and congregation members may therefore have lost confidence in a mental health field that sees religious faith as a problem and not a solution.

Congregants with mental health issues would benefit if there were a mental health integrated model of care. An integrated field utilises its available capital to support congregants who come to them for help. Dura-Vila *et al.* (2011) suggests a cohesive model for Christian leaders to reduce or disable the professional resistance to the mental health field. They particularly challenge the 'one-size-fits-all' attitudes of statutory health services to integrate professional medical expertise with indigenous knowledge. In this light, Leavey, Loewenthal, & King, (2007) propose that Christian ministers

would be a valuable tool for early intervention to assist psychiatry to re-frame patients' causal attributions from the supernatural to the natural (p. 558).

Anthropological and sociological studies suggest a significant cultural diversity in the supernatural causes of illness (Murdock, 1980, cited in Landrine & Klonoff, 1994). Razali, Khan and Hasanah (1996) pointed out that help-seeking behaviour and poor drug compliance in congregants are related to supernatural reasons. The assertion of Leavey, Loewenthal, & King, (2007) on the natural versus the supernatural alienates Jacob, one of the participants, from engaging with the mental health field as such an assertion is dismissive of spirituality. Jacob felt the belief in only natural causes of illness inhibits congregants with supernatural views from accessing services if prevented from expressing the belief in the supernatural causes of illness. This highlights the importance of understanding the spiritual background of the congregants when receiving treatment for mental health issues. Jacob's reference to the 'academic' (Chapter 5, p. 99) was to point to the perceived tension between the faith capital and power of psychiatry. The Christian leaders will struggle for formalised recognition, as their primary role is the cure of souls. Pattison (1993) points out that the secularisation of the role of Christian leaders is of primary concern as they resist adopting and formalising a position outside their religious calling. The pastoral activities of compassion, guidance, healing, reconciliation, forgiveness, love and many transpersonal values is essential in the religious field.

Some scholars report on the positive collaboration between spirituality, religion and good health outcomes (Cornah, 2006). Clinebell (1972) suggest that the church should view issues of mental health as an unprecedented opportunity to multiply its contribution to both the prevention and the therapeutic dimension of mental health. Clinebell and McKeever (2011) advocated a church life that saw itself as a restorative and redemptive community that cares and uses the congregation as an instrument of therapy. church members with emotional problems should not feel lonely and isolated, desperately needing to feel a sense of community with others.

The experiences of participants Emily and June reflect the complex dynamics of the faith habitus. Emily went through depression due to her son's illness but had not felt supported by her supervising minister. She felt unable to talk about her problems. Similarly, June felt constrained to be open about her burnout (see Chapter 4). Both thought they were better placed to encourage and care for their congregants by taking a positive attitude, breaking the silence by willingly speaking up about their mental illness. They were however unable to talk about their depression with their church leaders as they both felt the pressure of being asked to trust the Lord, coupled with the internal feeling of keeping quiet.

The evidence from the participants is that although church members come willingly to talk to them they, as pastors, feel inhibited when speaking to their superiors about their own mental health problems. "My senior priest doesn't want to know!" says Angelina. The tendency of her faith habitus to keep her quiet at the expense of dealing honestly with mental illness is denying the reality of the prevalence of mental health issues in the church community. Therefore, a field that only emphasises the positive aspect of belief in mental health issues or benefits is likely to suppress its members and perpetuate a didactic theological position that refuses to be influenced by their experience. If the religious field is not open to challenges from its members, then they are less likely to ascribe to other explanatory models of understanding mental health issues.

6:2.4 Mental health literacy

Jorm *et al.* coined the term 'mental health literacy' and defined it as "the knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm *et al.*, 1997, p. 182). Jorm (2000) clarified the term to include the ability to define mental health problems, the causes, risk factors, treatments and knowledge about available resources and services. Leavey (2008) and Heseltine-Carp and Hoskins (2020) suggest that insights into, and understanding of, mental health may determine Christian leaders' success in addressing the mental health needs of their congregants.

According to Karadzhov and White (2018) there is no recent study about the nature of the pastoral support the clergy offer, or their mental health literacy. According to Taylor *et al.* (2000) the quality of this mental health support has been linked to both their mental health literacy and perceptions of the aetiology of mental health problems (cited in Karadzhov & White, 2018). Furthermore, the clergy's mental health-related beliefs are indicative of their willingness to collaborate with healthcare professionals (Leavey, Dura-Vila, & King, 2012; Stansbury *et al.*, 2011). How Christian leaders therefore conceptualise mental health issues is crucial to the understanding of the utilisation and effectiveness of pastoral support in response to congregants' mental health needs using the NHS.

The analysis of the data confirms that Christian leaders have difficulty defining mental health, indicating a lack of understanding of the subject. Despite this lack of training and knowledge, congregants expect leaders to respond to their needs (Asamoah, Osafo, & Agyapong, 2014; Clemens, Corradi, & Wasman, 1978). Christian leaders are involved in the care of congregants with profound mental issues, and their willingness to engage corroborates evidence that Christian leaders are often at the forefront of caring for members with significant mental health issues (Oppenheimer, Flannelly, & Weaver, 2004).

Stanford and McAlister (2008) suggest that Christian leaders often find themselves inadequately prepared or supported in a pastoral role that engages with mental health issues. Leavey, Loewenthal, & King (2007) highlight the implication of resources which would impact significantly on congregants if recognised and supported by their central organisation and training bodies. Choudhry *et al.*'s (2016, p. 558) study about beliefs and perceptions of mental health suggested the central governing apparatus and training bodies are failing to prepare clergy adequately to support congregants with mental health issues. Studies conducted by Vermaas *et al.* (2017) - Christian clergy in the United States – suggest that the participants (ministers) in their survey could recognise some serious mental health issues but failed to recognise the *severity* of their presentation and the need for timely referrals.

Similarly, the Christian leaders in this study were not able to ascertain and make appropriate referrals. They felt vulnerable, inept, and guilty about their inability to care for members, believing they were failing congregants in mental anguish and distress. Such powerlessness was evident in the participants: Angelina and Olu, for example, were dissatisfied with the level of training for pastors in ministry. The training they had received did not meet the demand for the mental health needs of their church. The pastors are vulnerable as frontline mental health carers, as they fulfil a role as 'gatekeepers' for mental health services without adequate skill and training (Chalfont *et al.,* 1990). The insight gained from Angelina's anguish, expressed as "I don't know what else to do with this one" (Chapter 5, p. 14), suggests that the Christian leaders recognised their limitations and the complex nature of pastoral care in mental health. According to Choudhry *et al.* (2016, p. 1), despite the limited "beliefs and knowledge about mental health issues and their remedies" and many treatment options for mental health issues (Jorm, 2000), congregants require the support from Christian leaders. The broader implications are that more training in mental health care is needed to support the Christian leaders.

The fluency of mental health language will aid effective communication and build a partner relationship to help in the care of its members. Language as power and means of communication (Bourdieu, 1991b, pp. 163–170) can enhance proper integration, alienate collaboration between mental health professionals and the Christian Church, or estrange individuals who do not speak it.

The field of the mental health profession has preserved its professional dominance over the religious field, causing an unequal relationship between the two. It is therefore difficult for those in the religious field to maintain a valid recognised voice, as the mental health field depends on the accepted language to preserve the dominance of the profession. For Bourdieu, language is not only a way of communication, but also carries a dynamic power through which people or organisations pursue their interests and display their practical competence (Bourdieu, 1991b). Language determines one's position and

"sense of limits" (Bourdieu, 1985, p. 728). The use of language legitimises who you are in the field, and therefore creates a sense of withdrawal if you cannot demonstrate it, affecting your right to be listened to, to interrupt, to ask questions, and to lecture. It determines the degree of your involvement (Bourdieu, 1993).

Although a new language can aid effective communication, it can also impede it and create conflict. This is created when both the embodied and institutional capital of the habituses clash. Such a conflict between the two habituses may threaten cohesion within the field, to impede or inspire a desire or simultaneously hinder and inspire the collaboration of the two habituses. The thesis argues that any conflict within the fields is potentially a productive space for developing a new relationship, sharing ideas and reforming the identity of the field. However, according to Laitin (2000) this may not always be the case as the volatile nature of conflict and passions could threaten the fields, leading to disengagement. Because Christian leaders could submit to the subtle expectation of symbolic power structures within the mental health field, they will need to resolve their internal theological tension to hold an influential voice in the medicalised field. The need for the mental health field to protect itself and adhere to the rules has at the same time restricted any positive interactions with Christian leaders, encouraging existing hostilities and therefore isolating spiritual and religious care in mental health.

6:2.5 Summary and Conclusion

Studies in the UK support the findings of this research, in that pastors remain central to the pastoral care in many Christian societies (Leavey, Loewenthal, & King, 2007; Stanford 2007). The necessity of their participation in attending to people with mental health problems is increasingly recognised (Larson, Larson & Koenig, 2001). For example, in February 2018, Rudgard's article in the Telegraph reported that clergy's worries about parishioners' mental health are on the rise, and the strain on NHS services leaves people with nowhere else to turn (Rudgard, 2018). As the religious field seems to be taking on more significance than ever - as care provided for those with mental health issues by the Christian leaders increases, it is essential to re-examine

the restrictions that hinder the dynamic working relationship between the mental health and religious fields. A collaborative partnership will require an increase in cultural capital for both habituses to allow the integration of spirituality and faith in mental healthcare.

The above may become a challenge for the mental health professional field as other research findings suggest that most psychiatrists do not give credence to patients' spiritual and religious experiences (Cook, Powell, & Sims, 2009; Moreira-Almeida, Koenig & Lucchetti, 2014). Verghese (2008) remarked that the biological approach to mental illness tends to ignore the spiritual dimension, but holistic care needs to involve all the agents in the field.

Those Christian leaders competent at operating in their church field, with the skills, experience, intellectual and spiritual resources that are sought after and recognised by congregants, find themselves ill-equipped to work within the field of medicalised mental healthcare. The cultural capital they bring with them is marginalised, or even seen as toxic by the high-status medicalised field. The pastors find that the language they usually rely on does not count, so they feel silenced. The medicalised habitus may also see Christian faith as toxic, and this perception may be reinforced by scandals that have dogged the church in recent years. Those occupying the faith habitus feel less skilled to engage with the power of psychiatry; this is because those who are part of it feel inhibited by their lack of ability to use appropriate language within the mental health field. The Christian leaders consciously attempt to improve their field positions by attending mental health courses to acquire enough cultural capital so that they are valued and accepted or recognised in the field. The Christian leaders found researching themselves helpful and explored relevant issues they face when dealing with congregants. Most of the Christian leaders said they did not want to be turned into psychiatrists as they are first and foremost pastors.

NHS England (2015) sets out to radically change the way healthcare service is provided to give people greater control over their care, developing innovative ways to deliver care to people in their communities, and to ensure

better integration of primary and secondary care services. This is a strong argument for recognising the need for the Christian Church to be an equal player. The distribution of power in the relationship between church leaders and mental health professionals has, however, led to the isolation of Christian leaders and limited their participation. The need for necessary change in the relationship between the power of the mental health professional and the Christian leaders will encourage opportunities for Christian leaders to become skilled, and participate as collaborators in the mental health care of congregants.

The research reveals the unbalanced power dynamics between psychiatrists and their Christian patients; their professional worldviews need to acknowledge the divide between them and attempt to develop concepts and language to bridge the gap. In his article on the Christian activities and resources in the mental health field, Ryan (2017) suggested that because the language of the mental health field was of a clinical nature, the attempt to develop a distinctive Christian language and approach to mental health has proven difficult. His report proposed a possible road map for developing a Christian practice, which drew from biblical and Christian theological and anthropological reflection (ibid., p. 8). Creating an authentic Christian language of mental health from the perspective of sufferers will require a new way of engaging with the mental health professionals.

The analysis supports extensive and extended training for Christian leaders. While ad hoc mental health awareness education is essential, it does not go far enough to provide the necessary expertise to challenge existing religious prejudices or adequately support the congregants. The increase in the cultural capital of the faith habitus will ensure the respect of the other players in the field of mental healthcare. A new language added to existing knowledge will promote authenticity and legitimacy in addition to all previous theological capital, embodied, objectified, and institutionalised. Such education will reduce the different competing dynamics to balance the relationship between the religious field of the Christian leaders, the mental health field, and the broader field of the NHS.

The merged field needs to recognise the value of other professional capital in contributing to caring for people living with mental health issues. Any additional cultural capital introduced into the mental health field duly changes the field positions to allow different decisions or propositions about mental healthcare. For example, the cultural capital of the Christian pastors' value and training, education and experience should be welcomed and be respected in the mental health field. The challenge for Christian leaders is how they can find an appropriate language that communicates insights from the religious field without having to compromise their theological commitments when caring for congregants.

The implication of the findings is the need to equip Christian leaders with relevant cultural capital so that they do not feel intimidated and marginalised in the mental health field. They need to develop a proficiency that gives Christian leaders confidence to support congregants and collaborate with the mental health professional that looks after them. The research therefore suggests a paradigm of Christian engagement, contextualisation, as a way of making ministry relevant to the context of the mental health field of the NHS. To better support the Christian leaders, the researcher proposes training in public theology (a form of applied and practical theology), to enable communication in the mental health field and the broader field of the NHS. A detailed curriculum is needed, one that addresses the findings of the research and a theological reflection on prayer and demon possession to support Christian leaders in the pastoral care of congregants with mental health issues.

Chapter 7 Implications of research

7:1 Introduction

This final chapter summarises the contribution this study makes to the practice of Christian leaders in the mental health field. It will discuss broader theological implications and recommend a detailed curriculum to address the training needs of Christian pastors. In conclusion, I will reflect on the professional and personal impact of undertaking this research.

7:2 Overview and critical insights based on the main findings

The primary objective of this study (as documented in Chapter 1) was to use cooperative inquiry methodology to investigate the training needs of Christian leaders who are caring for congregants with mental health issues as well as using NHS services. Following the literature review, and the results from the investigation (which involved two groups of Christian leaders in the south east of England), four conclusions were drawn, and discussed in Chapter 6. A critical insight into the training needs of Christian leaders is deduced from the findings, and the implication of the results drawn. These are:

1. That the pastoral care of congregants with mental health issues would be more effective if Christian leaders were better equipped and trained
2. That such training will create the confidence and language needed to integrate the Christian leaders' contribution to the field of mental healthcare in medicalised paradigms (van Dijk *et al.*, 2016).
3. That this new distinctive training is needed to address mental health literacy; raise the level of competency of the Christian leaders to integrate spirituality and mental health; and sharpen their skills. This is in order to harness their unique spiritual role and expertise, and to support and stand alongside congregants experiencing mental anguish.

4. To offer a theological reflection on the issues of prayer and demon possession, to support the Christian leaders on the issues of aetiology.

7:3 What can be learned from mental health chaplaincy in the NHS

According to Merchant and Wilson (2010), the mental health chaplaincy's role has entirely changed within the past two decades, from the traditional religious models of care to adapt to the ongoing development of mental health services. The change was to address government guidelines and challenges stimulated by the NHS's evidence-based environment in which it found itself (Mowat & Swinton, 2005); and in light of broader critique from bodies such as the National Secular Society (National Secular Society, 2009).

Newell (2005) suggests that not all chaplains have welcomed the call for an evidence-based approach to chaplaincy as this conflicts with their sense of vocation and pastoral ministry. Pattison (2015) recounted the plight of one chaplain, who reported that he did not think there was going to be a place for theology in his thinking about the future of chaplaincy, given the multi-faith context of his practice. Another stated that many of the chaplains he knows regard themselves as anonymous Christians and would welcome discussion about the faith traditions that brought them into chaplaincy and sustain them in it. However, this no longer seems appropriate given the multi-faith context in which they minister (Pattison, 2015, p. 111). Chaplaincy in the UK is no longer solely a Christian, nor necessarily a religious activity (Fawcett & Noble, 2004; Swift, 2014, cited in Pattison, 2015).

In the NHS most chaplains, in addition to their theological training undertake further studies in counselling, psychotherapy, and transpersonal psychology so that they are qualified and skilled enough to establish their presence in the professional fields of the NHS. Several recommendations to address the efficacy gap are suggested in the chaplaincy literature. Merchant and Wilson (2010) highlight the concept of intentionality used in psychotherapy, which could be of use to chaplains to integrate ideas and interventions from different traditions. Another model put forward to affirm evidence-based working is from Rogerian person-centred therapy (Rogers, 1957), as he developed an

understanding of the necessary and sufficient core conditions that lead to personality change.

Harrison addresses the gap between theory and practice; and encourages psychologically-informed spiritual care in a dialogue with both psycho-social and medical care. He suggests 'radical presence', an approach to care which is a combination of contemporary spirituality, practical theology, and modules of person-centred counselling and psychotherapy (Harrison, 2017, p. 196). Harrison's model is a pastoral practice, drawn from Buber's (2011) existential philosophy of dialogue and built on the relationship between two persons which makes the presence of God possible. Essentially, this is a psycho-spiritual model for both professional chaplains in the mental health field and for Christian leaders interested in psychology and psychotherapy.

As discussed above, chaplains are increasingly adopting different psychological models in their pastoral role to support mental health patients in the NHS, and their roles are becoming less religious (Butler & Duffy, 2019; Engelhardt, 1998). 'Professional chaplaincy', or the psycho-spiritual chaplaincy, has brought about a degree of professional cooperation between pastoral caregivers and medical professionals. Moreover, although the Christian leaders in this study question the use of psychological models in congregants' care, as reflected in Angelina's phrase "we are pastors first and not trained clinical psychologists or mental healthcare coordinators and cannot provide the same expertise as a mental health professional. The Christian leaders need to recognise the use of chaplains to help build the relational bridge that can help them to foster collaboration in the mental health field".

7:4 Christian leaders in the NHS field

According to Pattison (2015), chaplains have offered different ways in the care of patients in the pluralist healthcare environment. Schuhmann and Damen (2018) draw attention to the challenges face by Christian leaders in developing an adequate and convincing model to explain their distinctive pastoral role in the public space of the NHS. In this pluralist context, the

challenge for Christian leaders is to find ways of working with, and a language that receives a positive response from, other mental health professionals; whilst at the same time allowing for their particular genius (Merchant & Wilson, 2010). The emergence of religious faith today, which dominates the public imagination, is quite different from what went before (Graham, 2013) and is now much more diverse than when religion was accepted in the NHS (Swift, 2014). It is in light of this that Graham (2013) suggested that if Christian churches were committed to any significant public role the nature of public theological discourse must change, as the public space is sensitive to, and suspicious of, religious discourse. In a mental health context where the professional association with religion is weaker, it definitely places greater responsibility on the importance of effective communication and the interaction between religion and society.

I argue that the mental health context poses challenges for Christian leaders, both in how they support congregants and their work in the public space of the NHS. For Christian leaders to establish a voice they must learn to contextualise their practice in the context of mental health care in a clearly defined public theology model. I explain in detail the terms contextualisation and public theology in section 7.5.

Graham suggested that those who want to work in the public domain,

> face the challenge not only of articulating theologically grounded interventions in the public square but of justifying and defending the very relevance of the Christian faith in a culture that no longer grants automatic access or credence (Graham, 2013, p. 27).

In this case, the use of public theology contributes critically to deconstruct unhelpful theological application, in order to usefully engage with the issues that the mental health field produces. Christian leaders will need a framework to promote their distinctive contribution to the mental health care of congregants and promote their unique spiritual and pastoral role in the NHS.

This thesis suggests ‘mingling’ as a way to contextualise the Christian leaders’ ministry in the context of the NHS. The generated themes will form

a knowledge base for the proposed training programme and reflect the distinctiveness of the mental health support offered by the Christian leaders. A model of public theology for the NHS mental health context will improve Christian leaders' engagement with mental health services in the NHS.

In order for effective mingling to happen I suggest developing public theology (Marty, 1974; Morris, 2016); and the contextualisation that Coe (1973; 1974) coined to address local situations in churches (Coe, cited in Joseph, Huang & Hsu, 2018). These models will facilitate the necessary dialogue needed to communicate with the mental health field within the NHS, the wider public, and the congregants for whom they care.

7:5 The rationale for contextualisation and public theology

The phrase 'public theology' is new to me, although contextualisation is not. Both the terms 'contextual theology' and 'public theology' are comparatively new (Garner, 2015) and both applicable to any field. I came across public theology while doing this doctorate. 'Theology' and 'public' put together made sense to me, so I read more on the subject. It was interesting to find out that, as a pastor, I have in some ways been both an applied and a public theologian in my pastoral encounters. Similar to my Christian leaders, simply using biblical verses to support the needs of congregants does not work, leaving us questioning its usefulness. The Christian leaders focused on applying theological truth to mental health issues and concentrated on the application of faith on issues raised in the vignettes, leaving out any critical theological dialogue. For the Christian leaders, biblical truth is above practice and emphasises the normative element of doctrine and revelation as guiding standard in practice. According to Heitink (1999), applied theology focuses on traditional thinking about how theology relates to practice based on objective truth, it is sometimes referred to as 'hints and helps' to indicate techniques used in learning (Campbell, 2000, p. 78; Hiltner, 1958, pp. 48-50). Graham, Walton and Ward (2005) pointed to the usefulness of applied theology because it is a theory, and its process results in improving Christian life. However, Hiltner (2000) pointed out that the application of doctrines alone cannot deal with different questions and situations in human life. The

data analysis suggests Christian leaders applied scriptures found in contemporary Christian fundamentalism, in which the application of scripture involves the movement from dogmatic or biblical norms to present experience and practice in a one way fashion (Osmer, 2011), leaving no room for reflective practice and reflection on experience and practice and dialogue with the social sciences.

Todd sees the problem with the applied model of theology as a 'technical' approach to ministerial formation, which focusses on particular skills of using 'objective' theory, such as exegesis for preaching (Todd, 2000, p. 38). Todd suggests that these skills are inadequate for the tasks of pastoral ministry, in the context of the diversity of field that requires flexibility and ability to contextualise, rather than merely employing the correct skills and/or applying theological concepts (ibid).

Therefore, the concept of contextual and public theology should be explored, examining how they might be applicable to Christian leaders supporting congregants who are also using the NHS mental health services, and its applicability in practice.

7:5a Contextualising theology

Coe (1973; 1974) formulated a model of contextualisation for theological education in order to address imported foreign structures in local church issues. He introduced a model for theological education to show how churches wrestle with their situated circumstances (Coe, 1973, 1974; Joseph, Huang & Hsu, 2018). Coe's contribution to the field of missiology is 'contextual theology', suggesting wrestling with God in a context that allows the context to inform or speak to theology. He proposed that theology is not a restatement of "past formulas or doctrines but a response to the self-disclosing initiative of the living God in history and human experience" (cited in Joseph, Huang & Hsu, 2018). For Bevans, there is no such thing as 'theology', there is only 'contextual theology' (Bevans, 2004, p. 3). He suggests that all theology is done from a particular point of view and a social location so as to understand the Christian faith in a specific context, and

argues that the contextual approach to theology is a radical departure from the traditional notion of doing theology to a dialogue-based theology between the experience of the past and the present (Bevans, 2018)

The application of scripture is essential to the Christian leaders, and theology devoid of Christian teaching is unhelpful. Therefore, it is important to suggest a model that recognises the important role of scripture and tradition; and also identifies the effects of culture, history, contemporary issues, and the human experience in shaping the context in which theological reflection takes place. Bevans (2004; 2018) suggests that a form of contextual theology enables Christian leaders to make sense of God and themselves in and through the world in which they find themselves and through a process of contextualisation through a dialogue between the past (scripture/ tradition) and the present (individual, current, and collective experience). The advantage for Christian leaders is that the results of contextual theology need not be traditional along the lines of dominant theological agreements. The framework allows flexibility in working with the context, without the feeling of being disloyal or betraying the faith.

I have outlined above the advantages of contextualizing theology. Contextualisation is not an easy process, as all contexts will have elements that oppose or compromise the Gospels and promote syncretism. Luzbetak (2002) defines syncretism in anthropology as the "synthesis of two or more culturally diverse belief or practices" or any theologically unacceptable mixture of religious beliefs (Langmead, 1988). According to Parshall (1998), the missiologist sees the relationship between contextualisation and syncretism as a continuum. He posited that one end of the continuum is low contextualisation and the other end is high syncretism. The low end of syncretism is where the church's culture is foreign to the community; and the high end of the continuum is where the foreign culture impacts significantly on the church and the Bible. The middle of the continuum is the meeting and blending of the opposing cultures.

This middle position is where the church adopts some problematic and challenging practices of the other culture but remains faithful. This model suggests a given mission is either syncretistic or not; it is also difficult to define the middle line between low contextualisation and high syncretism. Van Rheenen (2006) suggests the contextualisation for one missionary is another's syncretism; and so, it is difficult to draw a line.

The Christian leaders in the study did not discuss the direct witness and preaching of the gospel in the data but briefly discussing proselytising in this session clarify the Christians leaders' role in the mental health context. A study by Burford, Worrow and Caspary (2009) reported that evangelical Christians are expected to preach and convert others to faith, and they argued that proselytising is not welcome in the mental health field because of the problems it causes professionals. Van Nieuw Amerongen-Meeuse *et al.* (2018) pointed out that the fear of proselytising could be why professionals do not disclose their religious views. In this light, religious proselytism could be a barrier to collaboration, and Christian leaders denied a more significant public service role. Therefore, Christian leaders ought to restrain themselves from any tangible expression of faith (Bickley, 2015). However, Birdwell (2013) suggests that there is no evidence of aggressive proselytising, and this should not disadvantage the Christian leader's role in the mental health field. For the Christian leaders, the goal for contextualisation in the mental health field is not to proselytise or preach the gospel but to learn from the fields' strengths and weaknesses. That is to gain direct and immediate experience and knowledge and apparent challenges working in the mental health field and their professionals.

The issues raised by syncretism are essential for the Christian leaders, who see themselves as pastors first. Adopting ideas from psychology and demonic aetiology presents for them a compromising situation. It was difficult for them to decide which teachings of the church to retain or reject, or of any relevance when collaborating with the mental health field.

From a contextual theological position, Bevans (2004) maps a framework that the Christian leaders may find useful. He suggests considering three dimensions. Firstly, the experiences of individual and the context which involves personal experiences. Secondly, the experience of God as seen through culture; and thirdly the social location shaped by human predicaments such as gender, socioeconomic factors and mental health, to let people ask a theological question that is new. It is also important to consider how social locations prevent or oppress the theological voice, silencing or marginalising it (Langmead, 1988). This offers something distinctive to the Christian leaders that is also central to public theology, and it is to that subject I now turn.

7:5b Public theology

The term public theology attracts different meanings, and scholars of theology have applied it in many ways (van Aarde, 2008; Breitenberg, 2003; Graham, 2016). Valentin (2002) has pointed to the nebulous, changeable nature of public theology and suggests a careful mapping for its usage. Breitenberg (2003) indicates that the literature devoted to, and proponent of, public theology discusses it in one of three ways. I briefly state the proposed definitions here.

First, public theology is an informed religious discourse, understandable and convincing to a believer's religious tradition while at the same time being coherent and possibly persuasive to those outside it (Stackhouse *et al.*, 2014). According to Breitenberg (2003), those who hold this position focus on the question of whether theological arguments are available for public examination, and whether theological assertions are intelligible beyond the confines of a particular religious community. However, critics reject the premise that some forms of theology can be understandable or persuasive to those outside the faith traditions from which they arise (Cady, 1987).

Secondly, public theology addresses the issues of religious communities and the larger society, including those who identify themselves with either other faith traditions, or with none. According to Anderson (1998) this position

promotes the deliberate use of distinctively theological commitments to influence substantive public debate and policy, living out the religious tradition within its political environment. Following on from this, the third proponent of public theology relies on sources of insight, language, methods of argument, and warrants that are in theory open to all (Breitenberg, 2003).

Public theology therefore interacts or speaks to the professional context of mental health care in ways that facilitate critical reflection on the meaning and truth of claims expressed by Christian leaders within the mental health context (Breitenberg, 2003). And for Christian leaders to faithfully operate in the public domain of the NHS, Bromell (2011) suggests working within the context to go beyond the boundaries of one belief system. My findings suggest that Christian leaders work within their Christian traditions to provide theological interpretations and pastoral guidance for congregants, in ways that are understandable and convincing to those inside the church but not accessible to the mental health field. The use of public theology as the starting point for Christian leaders provides the link to start the conversation with professionals within the mental health field and address the issues that congregants face in a meaningful way.

Within the mental health field, public theology attempts to propose something distinctive rather than promoting what is already known in the religious field by deploying theology in public debate (Forrester, 2004). It is in this context that the mental health field sets the agenda, to which Christian leaders respond through theological engagement for the common good of all involved. If the Christian leaders reflect on listening and how that could be effective, then listening in the context of public theology involves the participation of both the congregants and the mental health professionals. In this way, the application of applied theology is not the starting point for Christian leaders; the problems of congregants and the mental health setting become the focus of theological reflection (Bromell, 2011).

This research proposes to introduce a way of working that is both critically respectful of the Christian leaders own classical theological traditions as well

as being critically open to the voice and emphases of theology that addresses the here and now. This is undertaken through a reflection on the issues that Christian leaders face when working within the mental health field (Bromell, 2011).

The suggested training programme draws on ideas from the context of public theology, as the study regards the National Health Service as public space and therefore needing a theology that can speak to its general culture. Contextual and public theology offers the Christian leader an opportunity for better engagement with the NHS with the "potential (for) building relationships, learning to understand each other, and growing in insight and wisdom" (Fensham, 2017, p. 397); and for a partnership in mental healthcare (Leavey *et al.,* 2011). In this way, the ignored voices and unexploited conversations of the Christian leaders will be the focus of theological reflection. To promote this, a reflective listening type of intervention does not only advocate the confession of faith. The Christian leaders, to remain faithful, use the perspective from contextual public theology to offer an appropriate way for negotiation within the public space of the NHS, enabling open and accessible dialogue (de Gruchy, 2007, cited in Graham, 2013, p. 120).

Contextual and public theology proposes how to respond to the key themes of the findings. Firstly, that the context of understanding theology is not optional, and Christian leaders wrestle theologically with the mental health issues of congregants. Secondly, Christian leaders need to maintain a healthy balance between church culture and the mental health field. The modus operandi to engage contextual and public theology is through theological reflection. Trokan (1997) proposes that theological reflection is an excellent tool that enables students to explore and critically reflect on God and public issues, leading to learning directly from experience. The learning outcome leads to new truth experience and meaning (Kinast, 1991). Walton (2002) points out that many scholars argue that the term 'theological reflection' relates to an approach to theology that takes as its starting point concrete experience or practice (the context). It does not explicitly begin with the

Bible, or church teaching, but instead starts with the enquiry from the existential concrete encounter.

7:5c Constructing theological reflection for the Christian leaders

The above argument lays the foundation for the use of theological reflection for the Christian leaders in this research. Trokan (1997) indicated the usefulness of these different models is that they do offer personal and theological insights into different pastoral situations. The Christian leaders in this study would benefit from a pastoral encounter that features some theological reflection due to its subject matter. Firstly, to understand the relation between Christian leaders' convictions and the broader mental health context, to identify the specific places where Christian leaders' convictions meet with the NHS's mental health field practices. Secondly, for the process of reflection, the Christian leaders draw on external knowledge or the proficiency of other mental health professionals or explanatory models in addition to their religious models. Thirdly, they pay attention to the context, and the interested parties within it. Finally, they demonstrate practical action that supports congregants' mental health needs. I will draw on two models proposed by scholars in the UK - Pattison's (2000) 'critical conversation' and Todd's (2000) model of theological reflection - to develop a pastoral reflection that will help my Christian leaders support their congregants.

Pattison (2000) suggests a model that involves a 'critical dialogue' between the pastor (reflector); tradition (faith proposition); and the experience explored or the particular context. This approach supports pastors in asking the right questions, then arriving at the best answers. This approach to practical theology, according to Pattison, helps to develop the conversation between religious experience and critical challenges in contemporary society by drawing on resources from secular knowledge, and thus connecting faith to the practice of everyday issues (Pattison, 2000, pp. 136-137).

A critical dialogue model encourages Christian leaders to have serious conversations with self and tradition (previous beliefs) and the interrogated field, so that faith remains relevant and brings theological insight to the

situation (Pattison, 2000). For my Christian leaders, the usefulness of this model is its engagement with the context. However, the intersection between the traditional beliefs and the contemporary individual is unclear and less specific, leaving the Christian leaders lost in the questions raised in the process of the reflection. Pattison acknowledges that this model has limitations, as the traditional model of theology is challenged (ibid).

Todd (2000), on the other hand, takes a comprehensive view of theological reflection. He took a critical view of inherited ways of doing theology and suggested the existing patterns are informed with rationalism and are therefore imperfect. He argues that the rationalism is contextual and cannot underpin generic theological reflection. Consequently, a new pattern for theology is needed to respond to the modern context by taking a hermeneutical approach to dialogue,

> This involves the person reflecting, seeking to establish a multidimensional picture of a situation-considering, locating and valuing the diversity of possible constructions (different points of view, political or theological standpoints, epistemologies and interpretations). The aim is to move from a 'thin', or surface, description to a 'thick', nuanced, complex description (ibid, p. 36).

Todd (ibid, p. 42) recommends a theological process model involving three movements that support Christian ministers in reflecting on practice:

(a) Engaging with context, which involves locating ourselves within both our human and broader environment, exploring our relationship to our socio-cultural and cosmic settings.

(b) Reflecting on ways we perceive our situation, consideration of how we see and know. Thus, seeing something new enables engaging differently with the context.

(c) Reflective action and doing the action (in action). It is in this third movement that theory is integrated.

7:5d Diagram to capture the tenets of applied and public theology models

In essence, applied theology uses the biblical text, ideas from biblical history and systematic theology to interrogate and analyse the mental health issues of congregants (Hiltner, 2000). Bromell suggests that applied theology is a Christian theology which fosters a theological understanding of Christian belief and practice in the church. It refers to the application of the biblical text to guide clergy's relationships with troubled congregants (Bromell, 2011, cited in Leavey, Rondon, & McBride, 2011). However, public theology, which is a form of practical theology, uses other available professional knowledge and sources, including medical, to critically reflect on mental health issues in the public arena. Figures 4, 5, and 6 explain the proposed interaction between the two fields.

Figure 4 shows the application of applied theology to the mental health field of professionals and the public. The diagram indicates the forceful application that makes the relationship between the two fields difficult and further alienates the Christian leaders, rendering them powerless in the mental health field of the NHS:

Figure 4

Applied Theology Model

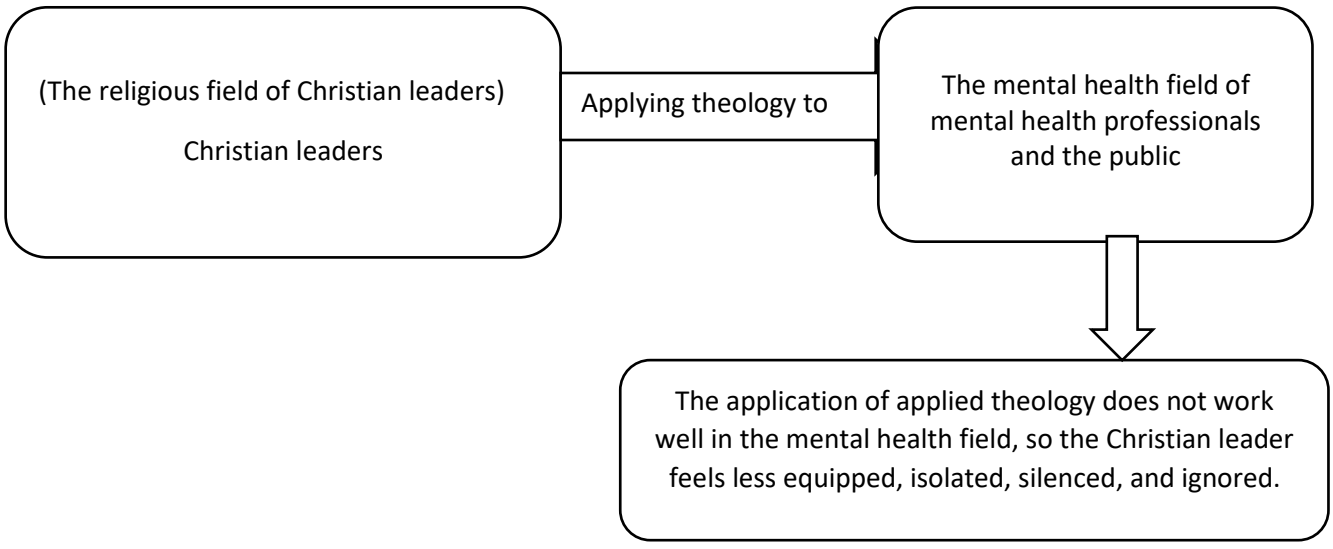


Figure 5 shows a way of being for the Christian leader who familiarises himself with the language of the mental health field to facilitate an exploratory conversation, promoting an inventive encounter when both are at ease with each other. It is not about fixing issues:

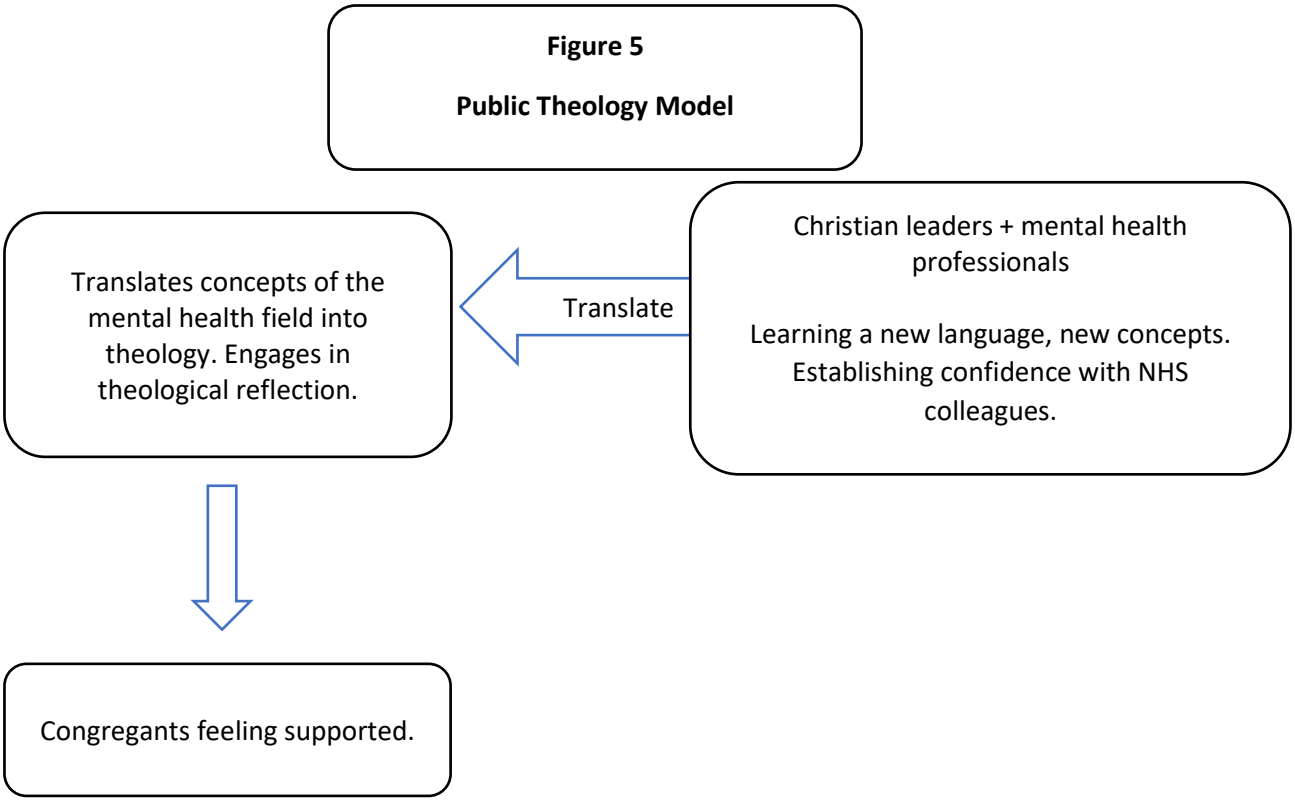
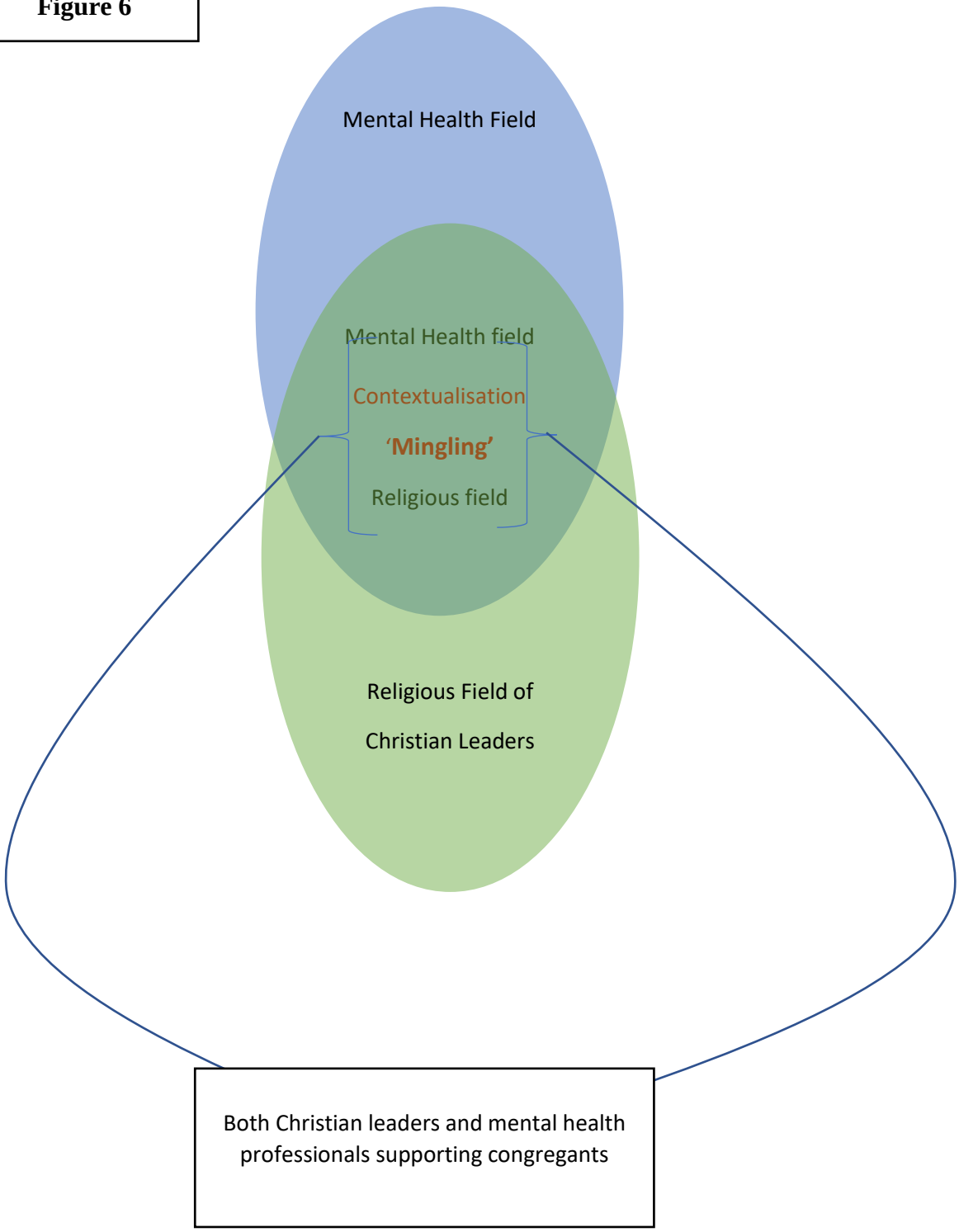


Figure 6 depicts Christian leaders 'mingling' with the mental health field, a type of contextualisation similar to what Hunter calls 'faithful presence' (Hunter, 2010, pp. 247-248). This type of 'mingling' affords the Christian leader an understanding of the context in which congregants receive mental health support:

Figure 6


Mental Health Field
Mental Health field
Contextualisation
'Mingling'
Religious field
Religious Field of
Christian Leaders
Both Christian leaders and mental health professionals supporting congregants

7:5e How do the models help the Christian leaders to 'mingle'

I will draw insights from the two theological reflective methods discussed in section 7:5c to develop a model of pastoral reflection to support the Christian leaders (participants) in mingling with mental health professionals, in order to manage the complex needs of congregants. I will then use the model to create a theological reflection on a vignette from Olu, a participant, to help the Christian leaders.

The diagram (Figures 7 and 8) below offers a step-by-step model for a theological reflection on Olu's vignette.

Figure 7

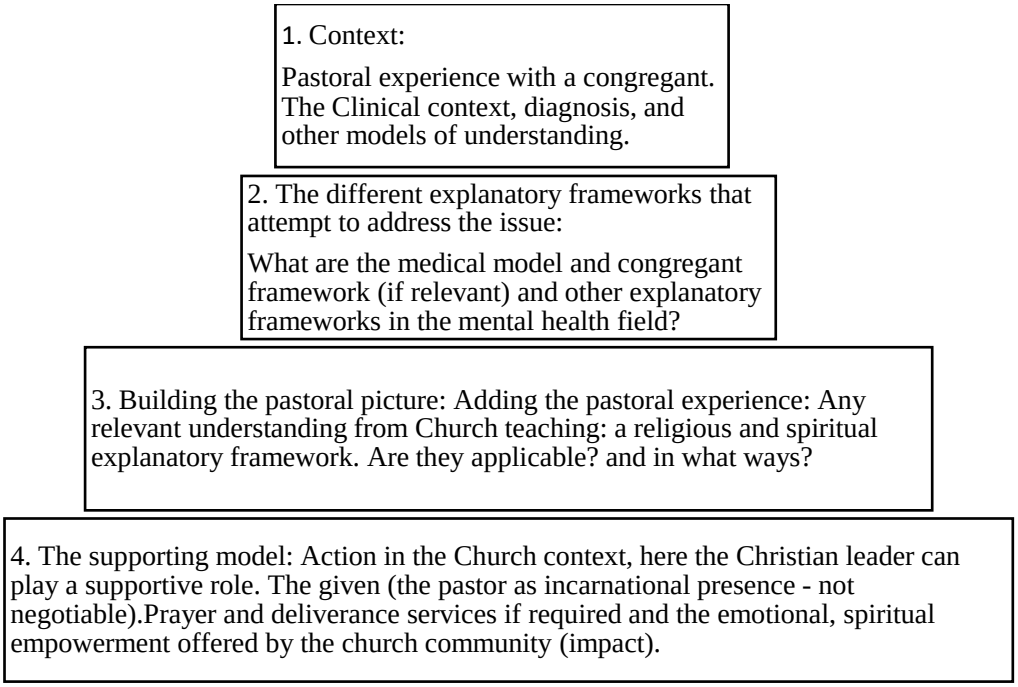
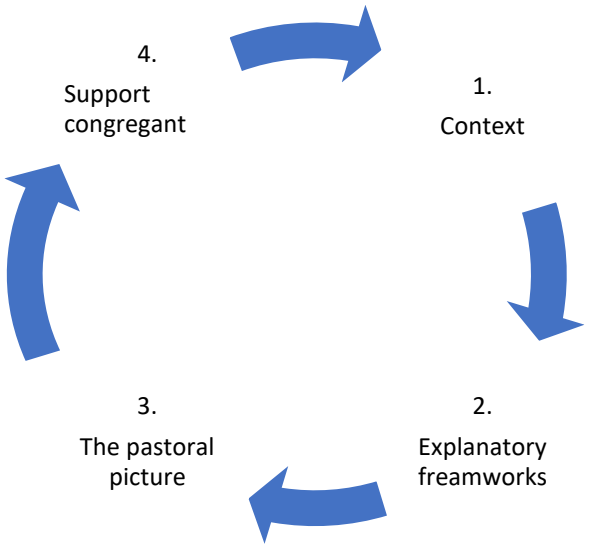


Figure 8 is a pictorial drawing showing the cycle phases of the step-by-step theological reflection model described in figure 7.



Olu's vignette:

A 39-year-old congregant named Eliza (not her real name) had attended Pastor Olu's church for over ten years. She was diagnosed with bipolar depression and was already living with enduring schizophrenia. Eliza heard voices in her head for many years. She was admitted to a mental hospital on numerous occasions. The voices she heard were persecutory and horrible to her. They said unkind words. Sometimes the voices were good, and she liked them, calling them angels. Eliza has a strong Christian faith, and, when well enough, would participate in Bible studies, prayer meetings, and enjoy the fellowship of the church members. Even though disturbed by the voices the desire to seek God remained strong, and she believed in the restorative power of Christ. She has always attended the church's deliverance prayer meeting. Eliza takes medications, some work, and some do not. She has also prayed for peace several times, for the horrible voices to go. Eliza is a devoted Christian, and her strong faith is seen as an obsession and a contributing factor to her mental health problems. For Christian leaders, this was a complex issue. As Olu said, 'We have been praying for years about Eliza's situation.'

First, I will examine the context:

Examining the mental health context of the NHS

The starting point for this congregant is the NHS, and it is vital to reflect on what the NHS stands for. It is worth noting that it is like any theological establishment that people turn to in time of need and brings people together (Neuberger, 1999). Like the church or other faith organisation, it represents health and dignity, offering healthcare to all poor or affluent. According to Neuberger,

> Klein described the NHS as a 'church for rationalists', created out of a missionary zeal born of the conviction that planning health care rationally and fairly was the best way to improve the nation's health (Klein, 1993, cited in Neuberger, 1999, p. 1588).

I have discussed how the status, power and privileges of the NHS's professional field disadvantaged congregants and Christian leaders and how tensions in the mental health field side-line Christian leaders. Christian leaders need to ensure that they understand these conflicts to recognise congregants' religious struggles and how the field's perception impacted their pastoral care. Thus, understanding the context begins the realistic appraisal of such difficulties at both clinical and religious level to engage the resources required to support congregants and foster partnerships in the field.

The NHS field is not static and, over the years, growing literature highlights emerging themes relevant to this research. The tension relating to religion and spirituality would focus on participants' suggested programme (see Appendix 2, session 6, parts 1&2). Understanding the NHS context will help Christian leaders appreciate how religion and spirituality permeate the NHS culture. What would the shift from religion to spirituality in the NHS mean for the Christian leaders who use religious language to describe their role from within their church habitus? The NHS context has its language to describe mental disorders. For Eliza's needs, Christian leaders must find a theological way to get alongside and help more effectively.

The mental health context has different specialities, roles, and responsibilities that provide various mental health services and support for congregants. To better support Eliza, Christian leaders must understand the speciality, roles

and language of Eliza's context. Mercer (2013) believes that understanding the context's language enhances Christian leaders' cognitive understanding of professionals who cared for Eliza. Christian leaders will have to understand both the standard and delusional experiences expressed in the language from psychiatry and Eliza's perspective. It is also essential for Christian leaders to find language that better supports Eliza within a spiritual and mental health context.

Mental health literacy will assist Christian leaders to establish a conceptual framework to collaborate and to be referral partners in the care of Eliza and ensure that she receives practical help (Leavey, Loewenthal, & King, 2007). As suggested by (Jorm *et al.,* 1997), satisfactory mental health language is crucial for seeking and receiving adequate mental health care. For this vignette, a language in mental health care helps Christian leaders demonstrate mental health literacy to help their religious obligations to Eliza and the NHS mental health care system.

Due to the increased demand for services with limited resources, there is a shift to value-based health care which describes compassionate approaches tailored to individual needs, and their rights in clinical decisions about their care (Hurst *et al.,* 2019). The shift to value-based healthcare, though not embedded, is gaining importance in the NHS care systems to promote the respect and dignity of all users of the NHS service, with elements and values of compassion for its users. This new value-based healthcare offers new challenges and opportunities for the Christian leader. The Christian leaders' understanding of the NHS's context lays the foundation for meaningful work with congregants and helps Christian leaders to mingle.

Secondly, to highlight the different explanatory frameworks that attempt to address the issue

Having set the context, I will now look at the different mental health field frameworks that supported Eliza while living with bipolar depression. A critical reflection on the explanatory framework is about mental health literacy, as discussed in Chapter 6. The vignette does not list the professionals

involved in Eliza's care, but I would like to discuss those who are likely to be involved, as not knowing the professionals caring for her denies knowledge about her treatment regime.

Dinos *et al.* (2017) suggested the explanatory model as the,

> complex and culturally determined process of sense-making of one's illness, ascribing meaning to symptoms, evolving causal attributions and expressing reasonable expectation of treatment and related outcomes (p. 106).

Christian leaders must understand Eliza's perceptions of her problems from her viewpoint.

Firstly, there are a series of mental health assessments from a family doctor, a psychologist, or a psychiatrist to check the evidence of mental illness. The rigorous process for determining whether someone has a mental disease form a psychiatrist is detailed in the DSM-5, a diagnostic and statistical manual for diagnosing mental disorders; and the International Classification of Diseases (ICD) (Stein, Lund, & Nesse, 2013). Essential clinical skills are required to complete a full assessment, which involves gaining a detailed understanding of the patient (Gelder, Gath, & Mayou, 1989; Jorm, 2000). The biomedical framework essentially dominates the assessment process and ignores other legitimate treatment paradigms that may offer support without a diagnostic label from the DSM and ICD. The mental health classifications in these manuals have been known to pathologise human behaviour. I fear that religious experiences may also be pathologised, which is also a concern for my Christian leaders and their congregants.

In the first year of becoming a mental health chaplain, I presented my role to a group of nurses. After my presentation one of the nurses commented "are you a psychologist or a priest, you sounded like a psychologist." I have been driven by the need to belong and fit into this strange new field, thinking that this will give me some legitimacy and authority. It felt as if I was afraid to talk about prayer and the Bible. Nouwen, reflecting on Christian leadership, highlighted the plight of Christian leaders such as myself, and suggests

thinking theologically or thinking with the mind of Christ is hard in practice as some Christian leaders use understanding from psychology instead of scripture (Nouwen, 1998, p. 53).

Nouwen (ibid) suggests that most Christian leaders are educated in a climate where behavioural science flourishes. As such "little true theology is being learned" and in raising Christian leaders without theological reflection, ministers run the risk of becoming anything that the field dictates. In this research, the Christian leaders were clear that their role was as a priest, not a social worker or a psychologist. However, paying attention to cross-disciplinary knowledge, which may surface as a result of engaging with a different framework, allows all in the field to consider collaboration essential in supporting congregants. Therefore, Christian leaders can appreciate other explanatory models and their relevance to the treatment of congregants. However, dilemmas may arise because of tensions within the different explanatory models; this will require a curriculum to help Christian leaders understand that faithfulness to scripture and understanding medical explanations can go together.

Third, building the pastoral picture: a religious and spiritual explanatory framework

The majority of the Christian leaders referred to prayers and deliverance as the standard response to Eliza's illness, and she has attended regular prayer sessions. The issues of demon possession and deliverance prayers is a contentious one, and I would like to offer a reflection. Jacob asked the group the genuine question, "why don't we consider demon possession?" and wondered why the group placed so much emphasis on medical diagnosis and treatment. Jacob's question raises two sets of additional questions: is there a legitimate place for consideration of demon possession in the medical field? And for the Christian leader is there a place for the psychiatry model in the church, or is there a link between demon possession and mental health problems?

Among many psychiatrists, demonology and exorcism is not discussed in the mental health field of the NHS; however, most congregants do want to know whether their problems are spiritual, or if they are possessed by a spiritual entity or demons.

The Old Testament writings associate demons with evil spirits or beings. In Hellenist literature, demons are referred to as deities (Hiers, 1974). The Greek word daimon, translated as a "demon", associated "demons" with evil spirits in modern English bibles by early Christian works (Hiers, 1974; Sherouse, 1983). There are references in the New Testament that recognise the reality of demons as the Gospels give accounts of Jesus' encounters with them. Jacob (a participant) was clear about this, and a brief survey of New Testament passages reveals that demon possession is considered real by the New Testament authors. However, whether the hearing of voices is demonic possession is difficult to tell. Some personalities in the Bible who heard the voice of God were considered to have either a religious experience, or to have mental health issues (Cook, 2019). Hearing voices is familiar to the general population and among those who have no psychiatric diagnosis (McCarthy-Jones, 2012).

Many people in the Bible hear the voices of angels, especially in the Old Testament, although there are examples in the New Testament. If a friend found me talking to myself and asked, 'who were you talking to' and I replied, 'to the snake over there', but he saw no snake, he would think something was wrong with me. There are similar examples in the Old Testament with angels, a donkey and a serpent talking to humans (Genesis 18:1-5; Numbers 22: 21-38: Genesis 3:14; Cline, 2010). St. Paul's experience of hearing a voice on the road to Damascus is another example, as he saw a light and heard a voice that no other person with him heard (Acts, 9:3-5). Voices play an essential role in the Gospel narrative, for example at the birth of Jesus in the book of Luke; voices heard at Jesus' baptism; Jesus' conversation with Satan; and the various angelic visitations in the resurrection narratives. Hermeneutically, these passages have often been interpreted as divine involvement and are not the same as those who hear voices today (Cook, 2019).

Are Eliza's problems demonic or celestial? How do I know if the voice is of God, or demonic, or something else? There is a potential overlap between those voices that are spiritual and those categorised in the medical field as a mental health disorder. Generally, there have been several methods proposed to build a set of principles to discern between different kind of voice-hearing (Watkins, 2013). Watkins' principles are helpful, but he suggests they are not absolute.

Some have argued that authentic spiritual voice-hearing tends to happen to those that aspire to spiritual values; while voices that are overwhelming and stop one from functioning in everyday life event are pathological. For Eliza the voices are sometimes negative and persecutory, but sometimes lovely and friendly. It seems to me that my Christian leaders' theological and pastoral task was to distinguish between the voices that are supportive and those which are not. The broader theological question is to determine the similarity of the voices that Eliza heard to biblical ones, and how she interpreted the voices she heard. A positive experience in discovering whether the voices are good or evil eventually leads to renewed well-being and a place of growth. Eliza hears voices, but still goes to church; she attends and values the prayer meetings, she still hopes for some miracle of healing.

Christian leaders from the Pentecostal background in this research felt obligated to teach about the influence of evil and demons, and the proper use of deliverance prayers in some cases. They felt demons' work in mental assessment is ignored because of scientific advancement but must be considered when offering pastoral care.

The relationship of the Christian leaders and mental health professionals regarding demon possession has caused tensions that are too strong to work collaboratively. However, this study does not offer to solve the tensions but reflect on lessening these tensions to focus on congregants' wholeness and pastoral needs (see curriculum Appendix 20).

The existing tensions cannot stop the Christian leader and mental health professional working together, so it is essential to respect the unique

perspective and exceptional quality of healing that deliverance brings to congregants. If Christian leaders are looking to foster a relationship with professionals in the mental health field and contribute to the holistic approach to care, they must understand the medical model to rule out pathological disorders. To understand the medical model is not to fully accept this perspective from empirical science because they risk the legitimate place of deliverance prayers for their congregant.

Christian leaders need to consider possible ways proposed by the mental health professional before performing deliverance prayers. It is essential to work with the proponents of the different explanatory framework in the mental health field to find the proper support for congregants and consult with others for cases presented as demon possession. According to Mercer,

> Anglicans and Roman Catholics make deliverance the task of ordained clergy and expect them to consider psychological and psychiatric concepts before taking a supernatural approach (Mercer 2013, p. 593).

In this light, McDonald (2012) suggests that any deliverance should only commence with careful preparation, after eliminating mental illness, followed immediately with pastoral care. The assessment must use a multidisciplinary approach with insights from pastoral care and theology, psychology, and psychiatry. However, Pentecostals often do not consider these essential to the task of casting out demons, nor do they consider any form of ordination training to be necessary (Mercer 2013). When congregants find the religious experience of deliverance beneficial on their recovery journey from mental health issues, Christian leaders must make it available in consultation with other colleagues or chaplain in the mental health field. Recent studies suggest that psychology professionals have become more open to engaging in demonology questions and the possibility that deliverance has validity in treating the afflicted (Mercer, 2013). Even if mental health professionals do not believe a demon is present, Christian leaders need to maintain the pastoral

support and explore possible deliverance prayers for the congregant to allow a deeper spiritual meaning for the distressed.

Public theology asks what the meaning of this event is, why is it happening, and how can we respond? In responding to issues that present as demonic, it is essential to remain true to our beliefs, and meaningfully integrate spirituality into pastoral care. The Christian leader must work with professionals in the mental health field to determine the root issue and provide ongoing treatment beyond the afflicted's improvement. Christian leaders must be careful not to immediately diagnose congregants with demon possession and prescribe deliverance to solve it. Also, doctors must not deny possession potential in all cases because of their different explanatory models.

In attempting to bring the argument about demon possession to a satisfactory close to the issues of demon possession and subsequent deliverance services for Eliza, it is evident that many questions remain regarding whether Eliza needs deliverance. The search for answers seems to only lead to further questions. This reflection aims not to offer a theology of demon possession in the light of the Bible to justify its use in Eliza's case, but to offer a valid argument for legitimate use in congregants' care. The question for me and most participants is, are we as Christian leaders failing Eliza? I wonder. Eliza has been seeking the restorative power of Christ from deliverance prayers. Having reflected on the issues regarding demons, I will now discuss the issue of prayer.

Christians have always prayed for each other, with the hope of intervention from God. Prayer as a religious practice is a complex and mystifying phenomenon (Bandak, 2017; Benson & Wirzba, 2005), seen across the world in most religions and even among those who are not religious. Therefore, it is not to be undervalued in human predicaments (Baesler, 2002; Immink, 2016). Deliverance seems to fail Eliza and Christian leaders. These are questions some of the Christian leaders contend with, demon possession as an explanatory framework requires Christian leaders to pray for congregants, as indicated in Olu's vignette. This type of framework is built fundamentally on

petitioning God. The problem arises when a connection is made between petitionary prayer and miracles. For example, if Olu's Church believes in divine response to petitionary prayer, are they also committed to a belief in miracles? Olu's Church continues to pray for Eliza. Demonic possession as an explanatory model requires congregants and Christian leaders to pray, and they will need to pray harder as suggested in the words of Olu "we have been praying for years, and no healing yet".

> Prayer is the raising of the mind and heart to God in praise and thanksgiving to Him and in supplication for the good things that we need, both spiritual and physical. The essence of prayer is, therefore, the spiritual lifting of the heart towards God. The mind in the heart stands consciously before the face of God, filled with due reverence, and begins to pour itself out before Him. This is spiritual prayer, and all prayer should be of this nature… the essence or the soul of prayer is within a man's mind and heart (Ware, 1981, p. 53, cited in Head, 2004).

The Christian ministry has a long history of prayer ministry with congregants experiencing mental and emotional anguish, however the phrases 'mental illness' and 'deliverance prayers ministry' is comparatively recent (Hunt, 1998). The meaning of deliverance varies from church to church, each carries different assumptions and theological understanding of mental illness in congregants. For one African participant, deliverance is a way of combating witchcraft or evil spirits (Onyinah, 2002) - a theology of liberation that depends on God's power to fight and expel evil spirits. Prayers of deliverance seek to break the harmful spiritual bonds formed by sins or wounds suffered in a person's life (Raoul, 2019).

The Bible does not present us with a systematic theology, or a diagnostic manual of mental health problems as does the DMS and ICD, but it provides the context of anguish in which theological reflections occur. Like Job in the biblical account, his comforters convinced themselves that Job's affliction was a punishment from God (Job 8:5). Job's mental anguish suggests a

context that those suffering from mental health problems have caused their illness. The general opinion was that emotional problems indicated not being right with God — the result of sin. Although not clearly stated in the vignette, there is a subtle question as to whether sin or lack of faith contribute to Eliza's issues. Webb (2012) suggests that mental illness, or mental anguish, is not a result of sin or lack of faith but a human predicament. For example, take the exegesis of the text in 1 Kings 19:4-8,

> while he himself went a day's journey into the wilderness. He came to a broom bush, sat down under it, and prayed that he might die. 'I have had enough, Lord,' he said, 'Take my life; I am no better than my ancestors.' Then he lay down under the bush and fell asleep.

In Elijah's desolation, God did not chastise him for lack of belief nor told him to improve his faith. Webb suggests instead,

> There is no coaxing of Elijah for increased prayer, nor any goading for repentance from sin. Instead, God approaches the prophet gently, attending to his weary body (Webb, 2012, p. 56).

We cannot tell whether Eliza's problems resulted from sin or the lack of faith or a causal effect between the relationship of self and illness. Also, Rae (2006) referred to the difficulty in understanding how mental illness fits our lives' overall fabric. The Bible, in general terms, supports the link between sin, sickness and death. However, sin and death are not part of God's original plan and therefore cannot generalise that mental illness is the result of sin (Nie & Olson, 2016).

Eliza, like Job, repeatedly appealed to God to understand the predicament, there was no miracle cure for Job, but God reveals to Job that He can be trusted which is embodied when we come alongside those suffering. Rae (2006) suggested answering why questions about the purpose of tragedy are not helpful in some situations but what sufferers find helpful is God's presence in the community of God who surrounds them.

Olu and Jacob (both participants) seemed to be looking for a miracle or some sort of healing that they felt prayers are not answered, which suggest that prayer is 'a cure-all' for problems or difficulties, regardless of the challenges and trials that accompany the Christian life (Pretorius, 2009). Head (2004), suggests that when prayers are too prescriptive, and particularly in the mental health context, it can lead to a 'quick fix' position and avoid the issues that calls for pastoral attention. The experiences of the participants show that prayer is an essential part of the ministry and remains a challenging aspect of the Christian tradition and a paradox perhaps as to whether prayers are answered or not. It is difficult to escape the conclusions about the efficacy of prayer from the perspective of the participants. It is not the efficacy of prayer that is being explored, but how it is applied. Notwithstanding,

> the feeling that God provides answers may bring comfort during times of distress, and provide rest, inspiration, and intimacy that may improve mood and increase a sense of purpose (Breslin & Lewis, 2008, p. 11).

However, notwithstanding that God answers prayer in times of distress and prayer recognised as an essential part of Christian leaders' ministry, I will reflect on a biblical verse in responding to the issue of prayer. Tiessen (2000), suggests that the authority of scripture is complemented by reason, tradition, and experience. Although scripture is unique in its traditional role in the world, the complex interplay of these factors demands a mixture of sound philosophy; proper use of the principle of rationality; the body of biblical historical knowledge of the church; and a careful reflection of our own experience in the world. The scripture often quoted to support this activity is James 5:13-16, which reads,

> 13 Is any among you afflicted? let him pray. Is any merry? let him sing psalms. 14 Is any sick among you? let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord. 15 And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall

> be forgiven him. 16 Confess your faults one to another, and pray one for another, that ye may be healed. The effectual fervent prayer of a righteous man availeth much.

Prayers are not magic spells, to twist the hand of God and get what you want, and at the same time, God uses prayer to accomplish His will. Personally, my prayers have not been answered in the way I would like them answered. Head (2004) suggests that prayers are not always answered in response to our will, but this does not mean that God has not responded, it means the matter is in God's hands, and outside our will, it is about discerning the will of God in difficult situations rather than to have instant satisfaction of personal needs. The theology of Christian prayer, for example, conveys this concept clearly in that Jesus himself exemplified how "prayer is an attitude of filial dependence, as opposed to magic where the prayer aims to manipulate the deity"' (Stone, 1995, p. 684, cited in Head, 2004).

Praying for God to intervene in accordance with His will is a difficult position to hold. Praying to twist or influence God or to buy His attention is leaving congregants who attend prayer meetings disappointed. But it is in prayer that we can carry in our heart pain and sorrow, conflicts and agonies, torture, loneliness, and misery as God's heart becomes one with ours (Nouwen, 1991, p. 86).

Nouwen's book on the solitude, silence, and prayer life of the fourth-century Desert Fathers may offer Christian leaders' insight into mental health prayer ministry. The Desert Fathers were early Christian hermits in the Egyptian desert from the third century who devoted themselves to austerity, prayer and work (Waddell, 1981; Wortley, 2019). Most of my participants are from the charismatic and Pentecostal Churches and, like myself, it is easy to be caught up in thinking that God is most pleased with noise, and "the binding and loosing prayer atmosphere of our worship" (Venetta). We become disappointed when a feeling of God has not been present, and emotions are not heightened.

Nouwen (ibid), through the lens of the 'Desert Fathers' offers a perspective on prayer that integrates faith into our own contemporary spiritual practice. We do not have to go into physical solitude to learn the lessons on prayer, but we often find ourselves in the loneliness of our society where we are required to enter into chaos and suffering to offer hope. Prayer then allows us to focus on time with God and come face-to-face with our nothingness; it helps us surrender to the lordship of Christ. It is into this space of nothingness, the place of being alone with God that real prayer comes, to submit to God rather than petitioning Him. Nouwen's reflection on prayer offers Christian leaders a pragmatic approach, a way to depend on God and His mercy in the face of human predicaments, to listen to God's voice which allows us genuine, fresh compassion for our congregants and the transformation that comes with it. I will now turn to the fourth step in the model.

Fourthly, this step discusses the supporting model, to suggest the role for Christian leader in supporting congregants.

This is the action phase, which I termed 'the given' to describe the supportive model following on from steps 1-3.

The given describes the presence of the Christian leader both to offer non-judgemental but curious pastoral support to the congregant; and to mingle in the professional field of the mental health system. This pastoral presence is not designed to answer questions relating to the congregant's predicaments, but rather to sit with congregants and allow the real issues to emerge. It is not the *why* questions that matter, it is the ability to go beyond these. The Christian leader's action is to act as an "external unifying centre" (Firman & Gila, 2002), a model used in psychosynthesis counselling as a way of being with people, and for that matter in other professional fields.

Assagioli (1888-1974), a psychoanalyst in Italy, described the external unifying centre as,

> an indirect but true link, a point of connection between the personal man (or woman) and his (or her) higher Self, which is reflected and

> symbolised in that object (Assagioli, 1965a, p. 25 cited in Firman & Gila, 2002, p. 118).

Christian leaders as external unifying centres can sit within any pastoral encounter to offer God's presence through their physical attendance to work on a level that allows the presence of God into the meeting. It means sitting and listening to congregants, to allow something to emerge, although being with a congregant in this way does not offer a 'quick fix' to problems.

Jesus' ministry was more about service than miracles, and if we too were to offer a ministry of service, our congregants would benefit. It is the atmosphere of the complete presence of God and nurturing a deeper supportive environment that God can fully hear a person through a human ear. In this encounter, the congregant is seen, and the struggles validated in the presence of the Holy Spirit. The role of the Christian leaders, as I have proposed above, reflects incarnational theology to respond to the diverse field of mental health. Caperon, Todd, and Walters (2018) suggest an incarnational presence to explore as a way of being for the chaplain. Walter's (2018, p. 51) image of the chaplain "standing in the world, looking around" helps highlight the distinctive practice of chaplains. The Christian leaders are not chaplains however, they operate from slightly different space, the local church of congregants using the NHS. Mingling allows the Christian leaders to step out of the local church into the professional field, with their presence there one of curiosity and a desire to understand that field. It is the understanding they bring and their incarnational presence that supports the congregant.

In this four-phase model, the first step offers Christian leaders the contextual understanding of the field to develop adequate knowledge of the setting with relevant people so as to understand its values to enable meaningful interactions. The second phase was to interact with the different explanatory frameworks to identify the Christian leaders' unique understanding of the field. The third phase was to use a vignette to reflect on Christian leaders' theological issues with congregants, which mental professionals identify as problematic. The fourth phase was to suggest a way of working. The model

offers Christian leaders a way of working, that allows Christian leader to hold the different frameworks in the mental health field together, so that their theology is not seen as functioning autonomously. This model helps the Christian leaders to function as public theologians and using the concept of "mingling", offers Christian leaders, the presence to expand their distinctive pastoral role to include other frameworks to support congregants. In this way, congregants are better supported in ways accepted within the religious and mental health professional fields.

7:6 Rationale for the proposed curriculum (Appendix 20)

My thesis explores the rationale for a curriculum to address Christian leaders' mental health training needs when supporting congregants with mental health issues using the NHS. Evidence from the research and elsewhere suggests the positive promotion of mental health and well-being within Christian communities. This is increasingly recognised as an effective and economically practical way of addressing this need, with Christian groups reliably identified as being well-placed to provide this support (Keynejad, 2008). There are multiple potential benefits to enabling people to access mental health support through local faith groups, which is essential to the Christian role.

As the literature suggests, Christian leaders are often people's first port of call if they are struggling, which can be due to the different worldviews operating in these communities when compared with statutory services. They can provide a valuable opportunity to help individuals explore their current difficulties within a safe and supportive environment, with the potential for discussion of further support or signposting as needed. Support of this nature may help to increase the use of statutory services by congregants. Therefore, spirituality and faith need to be considered part of an individual's overall well-being. This area however is reportedly consistently overlooked or dismissed by statutory healthcare professionals.

In supporting and interacting with people across the whole spectrum of need, Christian leaders are also well placed to offer support and interventions at a

preventative level. Such support may respond to the distress experienced by congregants, as well as being more cost-effective at a service level due to the potential for a reduced burden on over-stretched statutory services.

As such, the need for community organisations and charities including Christian leaders to be crucial partners in public healthcare (Levin, 2016) has been formally recognised within key policy documents regarding the future and sustainability planning for the NHS, for example the NHS Long Term Plan (FaithAction, 2017).

For several years, research has shown that Christian leaders feel under-resourced in this area (Cornah, 2006). Concerns are regularly raised around 'getting it wrong' when it comes to mental health support, particularly when considering those individuals experiencing distress at a clinical level (Leavey & King, 2007). In addition, links between statutory services and Christian leaders are often poorly established or non-existent, with distrust and suspicion toward the other present on both sides (Sullivan *et al.*, 2013).

These challenges can ultimately lead to Christian leaders signposting to local services and refraining from offering any further support themselves. The reverse can be the case, in which a Christian leader assumes full responsibility for supporting an individual's mental health need. This can leave the system vulnerable where risk issues are present, resulting in interventions being offered that are at best unhelpful and at worst can add to the congregant's distress. There is a need to provide training and resources around mental health and well-being for Christian leaders in this study.

The research has highlighted the need for Christian leaders to receive training in this area, given the unique demands of their role, and the fact that currently no training is formally provided as standard during their pastoral formation.

The programme seeks to offer a contextualised approach to training Christian leaders to interact with the NHS public (Appendix 20):

- Deliver high quality, evidence-based training to Christian leaders, concerning the issues of mental health, well-being, and pastoral care.

- Allow Christian leaders to explore the interface between their own beliefs and the models and ways of working espoused in the mental health field. The aim is not to promote a homogeneous, medically-based understanding of mental distress. Instead, it is expected that participants will emerge from the training with ideas around promoting mental health issues within the context of their faith and belief systems to inform theological response (Appendix 20, Main Topics of Study, point 4)

- Encourage in-depth theological reflection and reflective practice to incorporate own beliefs, background, experience and attitude and context (Appendix 20, Pastoral and Theological Reflective Practice)

- Facilitate the exploration of what they can bring to their own unique role. This is distinct in that participants are not required to qualify as counsellors or undertake 'social work in a dog collar'. Rather, the aim is to inform and empower them to make effective use of their own theology, skills and expertise (Appendix 20).

- Support Christian leaders to recognise the responsibility involved in serving people who struggle in this way, especially with regard to responding to risk and supporting those who have a diagnosis at a clinical level and who may require a different response.

- Mingling with professional from the different mental health field (Appendix 20, Main Topics of Study, point 1,2 & 5).

7:6a A commentary on how the curriculum is shaped by and embodies the outcomes of the research.

This section discusses how the curriculum (Appendix 20) is shaped by and reflects the results of the research. First, I discuss how it works with specific themes derived from the data analysis. Secondly, I discuss how Bourdieu's analysis has informed the development of the curriculum, and thirdly, I

discuss how the model of public theology/theological reflection has been integrated into the curriculum.

1. **How the curriculum works with specific themes derived from the data analysis.**

The specific themes identified in the research that are addressed in the curriculum are.

i. Spiritual approaches to mental health issues.

Among the key findings of the study were the challenges of demon possession and spiritual issues in mental health problems. In Appendix 20, Main Topics of Study 1 of the curriculum addresses whether mental health problems are the result of the demonic. This section of the curriculum addresses and reflects on Jacob's (participant) concerns about the medical field being "academic and scientific", the overrepresentation of the medical model, and the importance of spiritual input in mental health, all of which were discussed in Chapter 6, pp. 116-124. To gain a better understanding of the different explanation models, selected cases from psychiatrists, clinical psychologists, chaplains, and spiritual traditions are discussed in the curriculum (Appendix 20, Main Topics of study 1). In these presentations, participants will discuss theological issues from a religious or spiritual perspective. And by using a combination of clinical and spiritual expertise, the teaching methods facilitate the understanding and challenges inherent in dialogue with the different mental health explanatory models (Appendix 20, Main Topics of study 1, 2 and 4). As discussed above, Appendix 20 allows participants to explore themes such as demon possession, prayer, and deliverance with the aim of increasing their confidence in their role as Christian leaders in the mental health field and with their congregations in the religious field.

ii. Mental health literacy.

Mental health literacy is identified in the research as important in helping Christian leaders better understand mental health, enabling partnership with mental health professionals, and promoting help-seeking effectiveness of congregants. The curriculum incorporates knowledge of medical models embedded in the course to enhance Christian leaders' mental health literacy.

Appendix 20, Main Topics of study 3, provide a presentation by psychiatrists and psychologists regarding mental illness and treatment, as well as an overview of the clinical assessment process and its relation to religion. For example, (Appendix 20, Main Topics of study 2) places emphasis on understanding symptoms as they are experienced, as well as familiarity with diagnostic criteria and language to help Christian leaders understand the principles of intervention in mental disorders, assist them to recognise mental illness, assess its severity and facilitate referral to mental health services. In Appendix 20, Main Topics of Study 3 of the curriculum, as discussed in Chapter 6, pp. 116-133, Christian leaders are equipped with relevant cultural capital and skills to assist congregants and collaborate with mental health professionals.

iii. Pastoral Skills

In Appendix 20, Main Topics of Study 3, I discuss communication with an emphasis on integrating medical, religious, and spiritual language in a pastoral setting. This involves helping participants to develop pastoral skills like active listening, especially when considering public theology. Olu, June, and Angelina both emphasized that listening to congregants is challenging, as discussed in Chapter 6:2.2, pp. 116-8. A workshop on listening skills is taught in Main Topics of Study 3 of the curriculum. Participant's practice listening on each other using the "External Unifying Centre model" described on pages 164-5. The workshops will also involve listening to congregants and mental health professionals within the context of public theology model proposed in Chapter 7:5d. Congregants and professionals both participate in the workshops, which creates a context for contextualisation for course participants. In this educational context, reflective listening enables an open and accessible interaction, help participants integrate the external unifying centre model by listening to congregants, as discussed on page 165 (Appendix 20, Main Topics of study 3)

iv. Fieldwork

Participants would be required to plan and complete mental health projects in their local churches and submit a written report of the project and their reflections and learning. In the afternoon reflective sessions, participants

would share their results with the other course participants (Appendix 20, Main Topics of study 6). Pastoral and Theological Reflective Practice sessions on pp. 289-292 provides the objective for the field project.

2. The part played by Bourdieu's analysis in constructing the curriculum.

Bourdieu's notion of cultural capital and habitus was significant in constructing the curriculum for the education of Christian leaders. The data analysis suggests that paying attention to the tension between Christian leaders and mental health professionals was a key training need. Therefore, the curriculum must offer the opportunity for Christian leaders to increase their mental health knowledge and it does so by promoting a dialogue between the two fields. According to Bourdieu, the term cultural capital refers to the ability to use knowledge, behaviours, and skills to demonstrate one's cultural competence and social status (Bourdieu, 1986). In considering this view, the curriculum provides Christian leaders knowledge through the structure of the curriculum to increase their competence and status in the mental health field. The strong emphasis on case studies was to address themes in the four main findings discussed in Chapter 6 (p. 115). The curriculum promotes the enhancement of cultural capital for Christian leaders to develop the confidence needed to support their congregants who are NHS patients. The course content is delivered in a way that encourages and invites comment, feedback, and reflection. It is essential that participants feel able to voice their ideas, assumptions, and concerns, throughout the programme. This is key to exploring the habitus of the Christian leaders and their mental health activities and to their recognising ways in which their dispositions and experiences are constraining their ability to care or collaborate as well as ways to flourish. Therefore, Bourdieu influenced the construction of the curriculum in three ways. First, the teaching methods used by the curriculum allow the two different fields to come together so that the occupants of the two habituses, the Christian leaders and the mental health professionals can understand and examine their relationship and each other's ideas when working with congregants. Second, the coming together of the two habituses

facilitated by the curriculum reveals existing tensions, which are then addressed through reflections to increase the cultural capital of Christian leaders working in the mental health field. Third, the teaching methods can also increase Christian leaders' mental health cultural capital by expanding mental health literacy, thereby enabling them to operate in mental health fields. As well as learning a new language, Christian leaders create relationships with mental health professionals that facilitate collaboration with them (see Appendix 20, Main Topics of study 2 and 5, pp. 286-287).

3. **How the model of public theology/theological reflection is incorporated into the curriculum.**

In this thesis I have identified the key characteristics of public theology as practical rather than applied theology to interacts or speaks to the professional context of mental health care in ways that facilitate critical reflection on the meaning and truth of claims expressed by Christian leaders within the mental health context (Breitenberg, 2003). I have extensively discussed this in pages 132-144 in this thesis. The curriculum proposes to cover a wide range of themes and models in the morning class. The public theology model discussed in chapter 7:5e pp. 148-168 and described in Figures 7 and 8 are incorporated in the curriculum within the format of personal and reflective practice groups (p. 293) who meet during the afternoon sessions. Each participant would be free to develop their theological understanding of mental health issues following the applicability of the model. As part of the course, the afternoon group sessions reflect on theological issues and pastoral concerns that emerge from the thematic sessions and provide the space for participants to grapple with challenging theological issues and ideas, alongside one another. For example, a case study/presentation from course facilitators (Appendix 20, Main Topics of study 1 and 2) establishes the context and explanatory models as discussed on pages 148-168. This would have been extensively covered in the morning sessions and include understanding the clinical context, diagnosis, and other models of understanding, the assumptions, ideas, and responses and ethical issues arising in professional and pastoral practice, and the applicability of the biblical text in the mental health context.

The theological reflection model comes to light during the afternoon session. The session brings together, the context, different explanatory frameworks that attempt to address the issue, building the pastoral picture and the supporting model which focuses on action in the Church context as described in figures 7 and 8, pp. 117-44.

The curriculum proposes a structure that enables public theology to occur through the multiple conversations required to help participants address beliefs about mental health, religious traditions/heritage, and theological frameworks to deconstruct unhelpful theological application, in order to usefully engage with the issues that the mental health field produces. The curriculum offers the learning community the opportunity to encourage and critically engage Christian leaders in relevant difficult theological conversations, which embody the mental health experiences of congregants. Such conversations form the essence of constructing public theological understanding from practice (Appendix 20, Main Topics of study 4, 5, 6 and 7). The approach uses thematic and didactic teaching in lecture format and experiential forms of engagement in the classroom, with later reflection upon the experience. This approach aims to expand participants' imagination of how one might engage in the real-life mental health issues by exploring a few critical theological approaches. The first part of the programme focuses on issues derived from the research analysis, and the second part of the programme is where public theology/theological reflection occurs (Appendix 20, Main Topics of study 3, 4, 5, 6 and 7).

In addition, the use of a practicum allows theological reflection to take place. Christian leaders use new ideas from the programme and practice within the church context, or with congregants, to establish new ways of supporting them. The theological ideas from this encounter are another basis for reflection with presenters on the programme. In addition, Christian leaders are encouraged to consider journaling and to bring ideas and reflections to reflective practice groups during the course. In this way, Christian leaders deal with practical and theological issues they face in the mental health field. The conversation with both the needs of congregants and mental health professionals allows focused theological reflection. The pedagogy adopted in

delivering the curriculum ensures that the public theological model and theological reflection occur (Appendix 20, Main Topics of study 1, 2, 3, 4, 5, 6 and 7, pp. 286-7).

A summary of how the specific themes from the research are embedded in the curriculum.

The mode of training will consist of case studies, didactic seminars and group discussions which will focus on issues identified by the research. As per the course curriculum, the morning session will feature the delivery of new content related to a given theme. In this session, we will use both didactic teaching methods and other delivery models, including role-plays, demonstrations, questions and answers, and practical exercises. The session will be designed so that there will be ample time for observations, questions, and discussions. Each morning session ends with reflective practice. If numbers permit, course participants may be divided into smaller groups, to maximise the opportunity for learning and reflection. The aims and goals of these groups, as well as their proposed structure, are in the reflective practice sessions (see pp. 289 – 290). We end with a recap of the learning from the morning and then discuss any practical issues regarding class arrangements or assignments. Afternoon sessions are devoted to public theology and theological reflection.

7:7 Summary of this thesis' contribution to new knowledge

The researcher has focused on describing how Christian leaders can care for congregants with mental health issues, collaborate with mental health professionals and develop a partnership with mental health services by providing insight into their training needs. The research hypothesises that when Christian leaders are better trained and equipped to care for congregants receiving treatment for mental health issues, they gain the respect of psychiatric health professionals, and can work collaboratively and with confidence in the mental health field. The majority of research on mental health, religion, and spirituality has not focused on investigating Christian leaders' training needs, which has been the main aim of this research study.

The Christian leaders mentioned in this study have felt pressured to take training in either psychology or counselling to respond to their congregants' needs.

The analysis of my fieldwork is a contribution to knowledge. The new knowledge generated is that the Christian leaders find themselves ill-equipped to operate within the medicalised field and the 'hostile' NHS mental healthcare services.

When Christian leaders, with their faith and cultural capital come together with the medical practitioners in the medical field, they are not persuasive, but silenced, isolated, and seen as the problem. Cultivating a new skill is essential if Christian leaders are to meet their congregants' mental health needs. This new knowledge, resulting from 'mingling', uses a way of working where Christian leaders do not have to adopt the medical approach of working, but they are aware of it, and intending to learn - this is where training comes in. They are using the knowledge and wisdom of the medical field whilst remaining faithful to their pastoral role. Christian leaders immerse themselves fully in the mental health field and develop a mental health language to inform the way they work with congregants.

Mingling will either form a new understanding; or create a hybrid language from the combination of the theological and psychiatric vocabulary (Jackson, 1964). Mingling leads to a contextual theological approach adopted from the life experienced in the medical field. This thesis concludes that these Christian leaders' critical training need is to learn how to function as public theologians in dialogue with the mental health services, rather than as applied theologians working from within the religious field. This thesis proposes that this approach will enable Christian leaders to mingle in the medical field, better support their congregants and enable collaboration with mental health professionals.

7:8 Interaction between professional practice and research

Service to my fellow human being is my service to God, and this is a philosophy that I have maintained throughout my life. I first learned these

words at the age of ten, when I asked a pastor, “how do we serve what we don’t see”. He responded with these words to me, “the real service to our fellow human is service to God”. I later realised this was the central teaching of Jesus Christ. As human beings, we all face traumatic events in our lifetime, and during these difficult times we sometimes meet others who come to be alongside us or respond to extraordinary moments that speak to our pain. My passion is to bring good enough health, healings, and supportive moments to the majority of individuals I come across in this world. Becoming a pastor was perhaps a way of fulfilling this vocation.

The whole Doctor of Education experience has been a journey; a new chapter in understanding the world of pastoral care and chaplaincy, especially in my professional role as a mental health chaplain. It has also created another facet to my professional identity. I have noticed a notable, albeit gradual, shift along the continuum; from offering routine pastoral visits/care to providing spiritual care to people with severe enduring mental health issues, and also to those living with a learning disability. Pastoral care for people with mental health issues in Christian communities has led to a new interest in investigating the religious and spiritual needs of congregants with mental problems, and the psychiatric concerns of their faith communities.

This doctorate has positioned me positively on this continuum and encouraged me to work with other professionals. It has expanded my knowledge base, enhanced my understanding of the field of mental healthcare, and stimulated the development of further research in pastoral and spiritual care. I now feel able to have a meaningful dialogue and interact confidently within the different professional fields of the National Health Service. In my professional practice, I have gained a greater understanding of responding to the complex spiritual problems that many Christians are facing. In addition to the theological lens available to me, I have gained other theoretical lenses, particularly those from public theology which helped to bring to light other explanatory models for mental health issues.

There are no straightforward answers regarding mental health problems as a single approach solution, be it the medicalised or theological. Not only has my client work been enhanced, but my way of interacting with my chaplaincy colleagues has also improved. There has also been interest in my research: although not yet completed, it was a privilege to present part of my findings to medical professional as a continuing professional development training for doctors. Although only a few practitioners were in attendance, the invitation to speak at this programme means that there is a recognition of my professional development and acceptance amongst mental health experienced practitioners. This new relationship has enabled me to network with other professionals within the broader field of mental health practitioners.

The research has helped me to understand my professional context. It has informed my expectations to act appropriately and encouraged me to reflect theologically on the complexity of different situations involving my input. The professional understanding that I contribute to issues that are discussed at team meetings often prompted further analysis; it was attentive and promoted best practices at all levels. There is a barrier which hides the role of the chaplain. One of the obstacles is that the religious worldview is outside many mental health practitioners' experience, as they receive no education or training about religion (Weaver *et al.*, 2003).

Furthermore, the challenge is for chaplains to communicate the distinctive role of chaplaincy. There is an increasingly large and diverse body of professional specialists, with considerable claims for power and status and legitimacy (Collyer, 2017; McDonald, 2014), there is also my desire for recognition and a voice beyond the religious one. This inevitable is likely to shape my religious identity, though not beyond recognition. To hold a credible voice and contribute meaningfully to the clinical environment required me to remain faithful to the religious role and respond to the professionality that chaplaincy can offer.

Todd, (2015, p. 70-77) noted that secularism and secularity in the broader public are changing the face of chaplaincy. This has resulted in healthcare

chaplaincy and the wider spiritual care practice shared with other healthcare professionals having to adapt within such an environment. As a result, new chaplaincy models and frameworks for professionalising public practice have been developed (Pye, Sedgwick, & Todd, 2015).

As a spiritual caregiver, the challenge was to find a way of working with colleagues in healthcare through shared understanding in a shared space. Working within this context required an active form of practical theology that considers both the pastoral and professional, for the chaplain to engage in belief and faith. In such a field, I am implicated in doing theology, but what kind of theology? A theology that argued for the relevance of faith and belief in the context of multiple "secularities" (Todd, 2015; 2018) that continue to displace religion from the public square. The healthcare environment is contextual and requires a mixture of responses and strategies, including theology, and it is in this context, I find public theology valuable.

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9 Appendices

Appendix 1 Approved letter: Faculty of education research ethics committee

Canterbury Christ Church University

7th June, 2016 Ref 15/EDU/03

Dear Josiah

Project title: A cooperative inquiry with faith community leaders into how spiritual and pastoral care for people with mental-health problems provides insight into curriculum development for ministerial education and implementation.

Members of the Faculty of Education Research Ethics committee have reviewed your application and have agreed to grant approval. Your application was thorough and all supporting documentation was in place.

I confirm that you can commence your research. Please notify me (or my replacement as Chair of the committee), of any significant change in the question, design or conduct of the study over its course.

This approval is conditional on you informing me once your research has been completed.

With best wishes for a successful project,

Yours sincerely,

Dr Viv Wilson
Acting Chair, Faculty of Education Research Ethics Committee.

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Vice-Chancellor and Principal, Canterbury Christ Church University

Appendix 2 Introduction to MH issues in pastoral course syllabus

Department of Pastoral & Spiritual Care

Department of Pastoral & Spiritual Care Community

Training Programme

INTRODUCTION TO MENTAL HEALTH ISSUES IN SPIRITUAL & PASTORAL CARE

AIM: To equip participants with the relevant skills, knowledge and self-awareness of mental health issues to be able to provide appropriate pastoral care within a community/faith setting or/and to support people who are under the care of Surrey & Borders Partnership NHS Foundation Trust.

COURSE OBJECTIVES:

To increase knowledge of mental health conditions.

Understanding the role of religion and spirituality in mental health.

To be able to identify spiritual resources that are supportive of the person's mental health, and spiritual experiences that can be indicative of mental illness.

To undertake a mini-mental health project in your faith community

To increase understanding of psychological processes. (Pastoral psychology)

To demonstrate an ability to self-reflect and listen to others.

COURSE STRUCTURE: 10 weekly sessions x 2 hours

COURSE CONTENT: Seminars and Experiential Learning

COURSE ATTENDANCE: Participants are required to attend a minimum of 80% of the sessions.

SESSIONS' STRUCTURE

SESSION 1 Josiah

Part 1:

Welcome. Structure of the sessions

Introductions: exploring own issues and knowledge on mental health

Refreshments

Part 2:

What is mental health?

Experiential Exercises

The mental Health Continuum

Where are you? Evaluation of session

SESSION 2

Part 1:

General Introduction to the diagnosis of mental illness

Evaluation of Session

Refreshments

Part 2:

General Introduction to the diagnosis of mental illness

Individual Reflections and Evaluation of session

And Reflections on last week's session

SESSION 3

Part 1:

Reflections on previous session

Communication and Listening Skills 1

This will involve talking about yourself and a difficult situation you are facing; please think of something you can manage in 5 minutes

Refreshments

Part 2:

Communication and Listening Skills &

Field Project: Introducing Mental Health Field Project*:

& Evaluation of session [*See Appendix]

SESSION 4:

Part 1:

Reflections on last week's session

Communication and Listening Skills 2

More practical: your today…

Refreshments

Part 2:

Communication and Listening Skills 2 ‘An intense time.’

Evaluation of session and Practice of stillness

Practical: an intense experience.

ONE WEEK BREAK (to be confirmed)

SESSION 5:

Part 1:

Reflections on last week’s session

Early intervention in Psychosis I

When and how do we seek professional help?

Refreshments

Part 2:

Early intervention in Psychosis II and Questions arising

Evaluation of session

SESSION 6: Josiah

Part 1:

Reflections on last week’s session

Mental Health & Religion the Interface of

Spiritual & Pastoral Care

Refreshments

Part 2:

Conversation: MH & Religion?

Reflections /Evaluation of session

Questions about the project and update

SESSION 7 Josiah

Part 1:

Reflections on previous session

Suicide prevention

Refreshments

Part 2

Suicide prevention and pastoral care

Chaplaincy, Supervision, volunteering

Caring and confusions

Reflections /Evaluation of session

SESSION 8 Josiah

Part 1:

Reflections on last week's session

Recovery healing and cure! Discussion /

A view of the spiritual dimension of mental Health

Examples

Refreshments

Part 2:

Spiritual Crisis or other topics

Mental Health Field Research discussion –Findings:

Reflections /Evaluation of session

SESSION 9

Part 1:

Reflections on last week's session

Mental Health Field Research discussion –Findings:

5 minutes per person 2 mins questions

Refreshments

Part 2:

Mental Health Field Research discussion –Findings

Evaluation of session

SESSION 10

Part 1:

Reflections on last week's session

Mental Health Field Research discussion –Findings:

Refreshments

Part 2:

Mental Health Field Research discussion –Endings

Final Evaluation of sessions and giving out certificates

EXPECTED OUTCOME OF TRAINING

On completion of the programme participants will be able to demonstrate:

- A deeper understanding of their own spirituality/meaning/beliefs and increased awareness of the ability to respect other's spirituality/meaning/ beliefs.
- More knowledge of Mental Health Issues from a clinical perspective
- Developed and practised compassionate listening skills

- An ability to integrate their knowledge, skills and self-awareness in a way that respects both their own and other's vulnerability and strength
- Some knowledge about pastoral care in mental health settings
- An ability to apply knowledge and skill to support people with a mental health problem living in their own communities, and /or in hospital.
- Participants who have successfully completed the training will be better equipped to offer support for mental health issues in a community pastoral setting.
- Participants will be encouraged to seek ongoing support and supervision for any further pastoral work they do.

* N.B. Before acceptance for the role of Chaplaincy Assistant, applicants will be recommended and supported by a local faith community and will complete an application process (including references & CRB check), attend an interview, and agree to ongoing regular supervision.

Participants will undertake to research the following questions within their church, community or faith setting:

What provision is there within your church, community or faith setting for the needs of people experiencing mental health struggles? *

Consider the possibilities that you would like to see for enhanced mental health care within your setting. Are you able to identify any mental health needs that are not currently being met? *

To conclude your research, can you summarise your findings?

Present your summary to the class.

[This might mean e.g., specific training in mental health for pastoral workers, provision of drop-in listening times, support/supervision for pastoral ministers, informal opportunities for community contact such as a café, setting up small groups, inclusion of people experiencing mental health struggles in contributing to the life of the church, regular visiting scheme, crisis intervention awareness, etc.]*

Participants will be expected to write a short report of the research they have undertaken and then present it to the learning community. [250 words]

Please have your projects ready to present by session 8.

We are happy to help you develop your thinking so get thoughts down and send them in, and we will give you feedback!

The sooner you start, the more time there is to refine!

A small library of books will be available for borrowing.

Appendix 3 Invitation letter

Date

Dear Participants

Invitation to participate in Pastoral Care research

I would like to invite you to participate in a study I am conducting as part of my Doctoral degree in the Department of Education at Canterbury Christchurch University under the supervision of Professor Trevor Cooling and Dr Lynn Revel of the National Institute for Christian Education Research.

The title of the research proposal is "A cooperative inquiry with faith community Leaders into how spiritual and pastoral care for people with mental-health problems provides insight into curriculum development and implementation."

The proposed study is to evaluate and explore pastoral care issues in mental health with faith communities and how leaders manage the challenges of caring for those using mental health services. The study also aimed to provide insight into how a unique curriculum for pastoral and spiritual care in mental health could be developed and implemented.

The participants for this study will be taken from people who have completed the 10-week training in the Introduction to Spiritual and Pastoral Care Issues in Mental Health course.

Your participation in this study is voluntary, and it will take place in a mutually agreed location. The expected duration of your participation involves meeting for one hour, six times over the course of the year. It will be a good idea for the prospective participants to meet with me to decide the working roles and the establishment of the group.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me on 07919394170 or by e-mail at j.e.anyinsah366@canterbury.ac.uk. You can also contact my supervisor, Professor Trevor Cooling, National Institute for Christian Education Research, Canterbury Christ Church University by e-mail at trevor.cooling@canterbury.ac.uk

I would like to assure you that this study has been reviewed and received ethics clearance through the Research Ethics Review Board at Canterbury Christchurch University. However, the final decision about participation is yours.

I hope that the results of my study will be of benefit to your faith communities and other communities, which were not directly involved in the study.

I very much look forward to speaking with you and thank you in advance for your assistance in this study.

Sincerely,

Josiah Ekow Anyinsah

Researcher

Appendix 4 Letter to interested participants

Dear All-Southeast 2,

I would like to thank you very much for agreeing to participate in my Doctorate in Education (EdD) research project. We will be meeting at the …….. on the 17th of January 2017 at 6 pm for our introductory meeting. Please can you send ……..your name and car registration details if you are planning to drive?
The meeting on the 17th is just a preliminary briefing to ensure that you understand your role in the project and know what to expect when the project starts. After this initial, we will have three further meetings for those who will give consent to be co-researchers and co-subjects or participants.

The purpose of the thesis is to find out how pastors from the Christian faith community offer pastoral care to members living with mental health problems within their congregation and how the information gathered from the process will help to provide insight for ministerial training for curriculum development.

The following below are some things we need to keep in mind before our first meeting:

What's my role as a researcher?

This first introductory session is to clarify the research purpose and foster some sense of group cohesion and my role is:

•To open up ideas and experiences about pastoral care and establish a way of working as a group.

•To facilitate and to give information. To foster a sense of direction without being too directive and to maintain the balance between task and process; to

provide the tools of action and reflection; to manage the issues of conflict, leadership, gender, trust, power and boundaries.

•To get agreement about the task and the mode of working together.

•To provide a context for making sense of the total process so that a way forward is agreed and any consequential actions are taken.

•To make sure that your anonymity is protected, and confidentiality is kept. (Chatham House Rule applies)

•To protect voice recording material throughout the process and to destroy in accordance with our research ethics regulations.

What's your role as a participant?

•You have completed the ten weeks introductory course in mental health and pastoral care.

•You are a pastor or pastoral worker in a church context or involved in a mental health project

•You will be a co-researcher in this project, working in partnership with me by providing and collecting data.

•You will be involved in coming up with questions that will answer the research question.

•You will be involved in action(s) and reflections

•You will keep a reflective journal throughout the project; this will help with the collection of any new knowledge

The next three further sessions will be the:

The working phase:

This is the phase where we will formulate questions and engage in action and reflection cycles. For example, what questions do we need to ask to address the issue we are investigation? Participants will agree on a question, reflect on it, and then decide on something they can do together that answers the question. Participants will then reflect on what is it that they learned from that action and the process goes on until new knowledge emerges.

If, however the question is revised, we will decide on a new action to further the learning of the group. We will include and manage any strongly held beliefs and viewpoints as part of the inquiry process, then look at the assumptions which created the particular beliefs and then find the opportunity to stay together and retain different beliefs or redefine the question etc. or suggest action that may resolve differences.

We will continue with the action, reflect cycles until we come up with something the group feels is the answer, or run out of time or something that allows us to stop the enquiry.

Thinking about ethical expectations

As a researcher, I am accountable to the Research Ethics Committee in the Faculty of Education at Canterbury Christ Church University. This means that:

•All participants in the research will be asked to sign consent forms.

•Participants are free to withdraw from the research data collection at any point, without needing to give a reason.

•I have to be particularly careful to safeguard vulnerable students during voice recording.

•I will use portions of quotes from the meeting to validate parts of my thesis.

•All data will be anonymised, and all possible measures will be taken to ensure that individuals cannot be identified in the research report and articles.

•The data will be securely stored.

I hope this provides you with some information about what to expect on the 17th and I look forward to seeing at the ……. Hospital

Many thanks
Josiah Anyinsah

Appendix 5 Consent form

Canterbury Christ Church University

CONSENT FORM

Title of Project: A cooperative inquiry with faith communities into how spiritual and pastoral care for people with mental health problems provides insight into curriculum development and implementation.

Name of Researcher: Josiah Ekow Anyinsah

Contact details: 247 Old Lodge Lane , Purley Surrey ,CR8 4AZ
Tel:
Email: janyinsah@msn.com

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential	
4. I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Copies: 1 for participant
1 for researcher

Appendix 6 Southeast 1 & 2 Biographical Data

Southeast 1 Biographical Data

Participants (Pseudonyms)	Gender Identified with	Ethnicity	Education	Reason to take part in this research
Shania	Female	White British	MSc Psychiatry, Kings (Registered Nurse) Attended the 10weeks Introduction to mental health issues in pastoral care course.	Recompensed to the invitation to join the inquiry group. The group will benefit from my many experiences with congregants with mental health issues and training I have delivered to churches and the clergy and bible colleagues. Also to provide and share with the group relevant reflections on my experience.
Elia	Male	White British	BSc Soton 1978, BD. Spurgeon's College 1998, Certificate in Pastoral Counselling Roehampton 2000 Attended the 10weeks Introduction to mental health issues in pastoral care course.	I currently work as a part-time Mental Health Chaplain. To further the understanding of the need for the clergy led mental health awareness, education and support network in the churches, particularly now that mental health care is delivered mostly in the community. Moreover, the need for the Pastor support structures within the church hierarchies for the mental health of clergy. My experience will enrich the participant group.
Emilia	Female	White British	Attended the 10weeks Introduction to mental health issues in pastoral care course.	I have been a vicar for 23 and have an interest in Mental Health issues and psychodynamic psychotherapy. My experience would be valuable and also learn from participating ministers.
Angelina	Female	White Britsih	Attended the 10weeks Introduction to mental health issues in pastoral care course.	I work as a Team Rector/Vicar, and I am interested in sharing with others my experiences about congregants with mental health issues. To research into the training need of the clergy who are at the forefront of mental health care.

Abby	Male	Black African	Facilitates the 10weeks Introduction to mental health issues in pastoral care course.	To research with pastors to explore and investigate how they as Christian leaders dealt with and support members with mental health issues. What helped and what didn't. What training needs would support them in their pastoral encounter with congregant's mental illness? My conversation with the Christian leaders will help to identify further training needs that need addressing.

Southeast 2 Biographical Data

Participants (Pseudonyms	Gender Identified with	Ethnicity	Education	Reason to take part in this research
Erica	Female	Black British Caribbean	BA Home Economic & Resource Management. I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I have been in Christian ministry over 25 years I joined the research group for the advancement of education in mental health and to find a theology that engages with mental illness and find training that educates Christian leaders in mental health care. My experiences with congregants with mental health issues will help provide some reflections on scenarios.

Jo	Female	Afro-Caribbean	Goldsmith University I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I have worked in the Church for 20 years as a part-time leader. I would like to see the introduction course achieve academic significance, an accreditation, a higher level to attract more interest and to train faith community in caring for members within faith communities with mental health issues. pastors like myself to develop the know-how to assist our communities in the mental health system. Furthermore, to work with/and engage in the field of mental health as service providers/researchers
Jacob	Male	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I am a pastor of a House Church for over 20 years and would like to share with others my experiences about congregants with mental health issues. To share and explore ideas with fellow ministers to increase knowledge.
Lalita	Female	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I am a Christian church leader with members suffering from mental health issues in my church and have struggled to care for them. I hope this research will help me resolved and acquire knowledge of something new. It is an opportunity to discuss and share our experiences together in the hope of learning something new.

Olu	Female	Black African	BSc (Hons) Business Management I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I am now retired from active pastoral ministry after 45 years of ministry. I have enough experience to contribute to this research. To share my experience working with people with mental health issues in my church. To increase my knowledge through the group as we inquiry into our training needs as Christian ministers in caring for members with mental health issues. And although I am retired, and still active, I believe my experiences will be useful to the group.
Venetta	Female	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I am a pastoral assistant in my church. I am also involved in pastoral care for a member with mental health issues. As a Church, I find that we rely a lot on divine intervention - more healing which although useful had not been entirely been adequate. Sharing my experiences and discussing some of the issues facing my church at this forum will highlight our needs and identify ways forward.
Kay	Female	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I decided to be part of the research group because of the growing mental health need of my Church. Some of my congregation members are living with mental health problems, and sometimes deliverance prayers and healing don't seem to come supernaturally. As a leader, I often struggle to offer support and try to avoid mental health issues altogether. Taken part in this research was to provide the

				group with my experience and also share wisdom and learn together.
Blessing	Female	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	A member of my church who loved the Lord and committed to the work of the church was diagnosed with bipolar disorder and his frequent episodes and struggles were very intense, which affected him emotionally and incapable of functioning in day-to-day living. The church prayed with this person for a few years now, to be set free. Mental health issues are serious matters in my church; I would like to understand and be better equipped to handle cases of mental illnesses in my church. I saw the inquiry group as fact-finding and solution focused. I hope to gain something new to help with my pastoral skills.

Abby	Male	Black African	Facilitates the 10-weeks Introduction to mental health issues in pastoral care course.	To research with pastors to explore and investigate how they as Christian leaders dealt with and support members with mental health issues. What helped and what didn't. What training needs would support them in their pastoral encounter with congregant's mental illness? My conversation with the Christian leaders will help to identify further training needs that need addressing.
June	Female	White British	*BA Hons Health & Community Studies* *Diploma in Salvation Army Officership* I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	I am a Minister of Religion, a Chaplain working with homeless young people. I have volunteered for the church since a teenager and ordained as a church leader for 14 years. The research is an excellent opportunity for me to share knowledge & experience, also to learn from others
Yvonne	Female	Black British	I also attended the 10-weeks Introduction to mental health issues in pastoral care course.	Explore mental issues of my congregation and support this research with my experience and learn from other pastors experiences.

Appendix 7 First Meeting - Cooperative Inquiry Participants

Phase	Main Theme	Activities	Timeframe Southeast 1	Timeframe Southeast 2
1	Forming the inquiry groups	Conversation with my supervisors on the number needed for a potential group. The difficulty in getting 10-12 participants.	29 February 2016 to 10 October 2016	
2	Getting the group together	I sent out 30 invitation letters to church leaders who attended my ten weeks of mental health and pastoral care introduction course. I make telephone calls to explain to people who need further explanations about the research. Receiving responses from willing to contribute to participants.	25 July 2016 - 07 December 2016	23 November 2016 - 17 January 2017
3	First Initial Meeting or introductory meeting Creating a safe environment and discussion of my proposal	Establishing my role as cofacilitator; ground rules for sharing personal stories, hopes, and fears. Recruiting onto the project and signing the consent forms and risk forms.	7 December 2016	17 January 2017

4	Getting started	Developing individual inquiry questions and personal reflections. Agreed to capture a summary of the discussion on a flip chart, to audio record reflection. Together with the group, we agreed to a partial form of cooperative inquiry. Here at a political level, both the researcher and participants are equally involved. At the epistemic level, the principal researcher is a partial participant, whilst all others were full participants. The research, authorship: The group agreed for the principal researcher to be the sole author of the research. None of the participants directly or indirectly expressed a desire for co-authorship and the responsibility for the content and presentation of the thesis is the responsibility of the principal researcher.	7 December 2016	17 January 2017
5	Kinds of Participation	Discussions on types of participation: All the Christian leaders were fully coresearchers in the decision of the research and fully subjects in the experience.	7 December 2016	17 January 2017

Appendix 8 A short guide to co-operative inquiry

A short guide to co-operative inquiry (Reason & Heron 1996)

Peter Reason and John Heron

What is co-operative inquiry?

Co-operative inquiry is a way of working with other people who have similar concerns and interests to yourself, in order to

understand your world, make sense of your life and develop new and creative ways of looking at things

learn how to act to change things you may want to change and find out how to do things better

We usually think of inquiry and research as something done by people in universities and research institutes. We think there is a researcher who has all the ideas, and who then studies other people by observing them, asking them questions, or by designing experiments. The trouble with this kind of way of doing research is that there is often very little connection between the researcher's thinking and the concerns and experiences of the people who are actually involved. People are treated as passive subjects rather than as active agents.

We believe that good research is research with people rather than on people. We believe that ordinary people are quite capable of developing their own ideas and can work together in a co-operative inquiry group to see if these ideas make sense of their world and work in practice. A second problem with traditional research is that the kind of thinking done by researchers is often theoretical rather than practical. It doesn't help people find how to act to change things in their lives. We believe that the outcome of good research is not just books and academic papers but is also the creative action of people to address matters that are important to them. Co-operative inquiry

thus embraces what is called action research. It is also concerned with revisioning our understanding of our world, as well as transforming practice within it.

In co-operative inquiry a group of people come together to explore issues of concern and interest. All members of the group contribute both to the ideas that go into their work together, and also are part of the activity that is being researched. Everyone has a say in deciding what questions are to be addressed and what ideas may be of help; everyone contributes to thinking about how to explore the questions; everyone gets involved in the activity that is being researched; and finally, everybody has a say in whatever conclusions the co-operative inquiry group may reach. So, in cooperative inquiry the split between 'researcher' and 'subjects' is done away with, and all those involved act together as 'co-researchers' and as 'co-subjects'.

Some examples of co-operative inquiry groups

A group of general medical practitioners formed a co-operative inquiry group to develop the theory and practice of holistic medicine. They built a simple model of holistic practice, and experimented with it in practice, exploring a range of intervention skills, power sharing with patients, concern for the spiritual dimensions of doctoring as well as attention to their own needs as medical practitioners. The experience of this study contributed to the formation of the British Holistic Medical Association. This study was taken forward when a group of general and complementary medical practitioners worked together to explore how they might effectively work in an interdisciplinary fashion.

A group of obese and post-obese women explored their experience together, looking in particular at how they were stereotyped in society, and how it was difficult for them to obtain appropriate attention from doctors and other medial people. This is one of several inquiries in which groups of people with a particular physical or medical condition have worked together to take charge of how their condition is defined and treated. Two black social work teachers established inquiry groups of black social work students,

practitioners and managers to explore their experience. They looked at relationships between black people at work, particularly the experience of black managers and subordinates working together; and how a creative black culture could be generated.

Several inquiry groups have met to explore ritual, mystical and subtle experience in an attempt to create forms of spiritual practice which are appropriate to present times.

Several groups have formed to explore questions of gender, in particular experience of women and men at work. One inquiry looked at how black women might learn to thrive, as well as survive in British organizations. Another explored the experience of young women managers in primarily male organizations. And another is looking at whether men in organizations need to explore questions of their gender in the workplace.

How a co-operative inquiry group works

Co-operative Inquiry is a systematic approach to developing understanding and action. And while every group is different, each one can be seen as engaged in cycles of action and reflection which go something like this.

The first thing is to bring a group of people together who have a common interest. In phase one a group of co-researchers come together to explore an agreed area of human activity. In this first phase they talk about their interests and concerns, agree on the focus of their inquiry, and develop together a set of questions or propositions they wish to explore. They agree to undertake some action, some practice, which will contribute to this exploration, and agree to some set of procedures by which they will observe and record their own and each other's experience.

For example, a group of health visitors in south west England were invited by one of their colleagues to form an inquiry group to explore the sources of stress in their work. After much resistance to the idea that they could be 'researchers', the group decided to explore the stress that comes from the 'hidden agendas' in their work - the suspicions they had about problems such

as depression, child abuse, and drug taking in the families they visit which are unexpressed and unexplored.

In phase two the group apply their agreed actions in their everyday life and work: they initiate the actions and observe and record the outcomes of their own and each other's behaviour. They may at first simply watch what it is that happens to them so they develop a better understanding of their experience; later they may start trying out new forms of action.

The health visitors first explored among themselves their feelings about these 'hidden agendas' and how they managed them at present. They then decided to experiment with confronting them. They practised the skills they thought they would need through role play, and then agreed to try raising their concerns directly with their client families.

In phase three the co-researchers become full immersed in their experience. They may become more open to what is going on and they may begin to see their experience in new ways. They may deepen into the experience so that superficial understandings are elaborated and developed. Or they may be led away from the original ideas and proposals into new fields, unpredicted action and creative insights. It is also possible that they may get so involved in what they are doing that they lose the awareness that they are part of an inquiry group: there may be a practical crisis, they may become enthralled, they may simply forget. This phase is in some ways the touchstone of the inquiry method and is what makes it so very different from conventional research, because here people are deeply involved in their own experience so any practical skills or new understandings will grow out of this experience.

The health visitors' experience of trying out new ways of working with clients was both terrifying and liberating in ways none of them had expected. On the one hand they felt they were really doing their job; on the other hand, they were concerned about the depth of the problems they would uncover and whether they had adequate skills to cope with them. The woman who had initiated the project in particular was anxious and had

disturbing dreams. They found they had to keep in good contact with each other to provide support and reassurance as they tried out new behaviours.

Phase four, after an agreed period engaged in phases two and three, the coresearchers re-assemble to consider their original questions in the light of their experience. As a result, they change their questions in some way; or reject them and pose new questions. They then agree on a second cycle of action and reflection. They may choose to focus on the same or on different aspects of the overall inquiry. The group may choose to amend or develop its inquiry procedures - forms of action, ways of gathering data - in the light of experience of the first cycle.

The health visitors came back together and shared their experience, helping each other understand what had taken place and developing their strategies and skills at confronting hidden agendas. After several cycles they reflected on what they had learned and wrote a report which they circulated to their managers and colleagues.

A co-operative inquiry often engages in some six to ten cycles of action and reflection. These can take place over a short workshop or may extend over a year or more, depending on the kind of questions that are being explored.

The kinds of knowledge a co-operative inquiry group can create

Co-operative inquiry involves at least four different kinds of ways of knowing. We call this an 'extended epistemology' - epistemology meaning a theory of how you know and extended because it reaches beyond the primarily theoretical knowledge of academia. Experiential knowing is through direct face-to-face encounter with person, place or thing; it is knowing through empathy and resonance and is almost impossible to put into words. Presentational knowing emerges from experiential knowing and provides the first form of expression by drawing on expressive forms of imagery through story, drawing, sculpture, movement, dance and so on. Propositional knowing 'about' something, is knowing through ideas and theories, expressed in informative statements. Practical knowing is knowing 'how to' do something and is expressed in a skill, knack or competence.

In co-operative inquiry we say that knowing will be more valid if these four ways of knowing are congruent with each other: if our knowing is grounded in our experience, expressed through our stories and images, understood through theories which make sense to us, and expressed in worthwhile action in our lives. You can see that this was so for the health visitors in their work together.

Other ways to improve the quality of knowing and action

You will see by now that co-operative inquiry is a radically different way of doing research. It is based on people examining their own experience and action carefully in collaboration with people who share similar concerns and interests. But you might say, isn't it true that people can fool themselves about their experience? Isn't this why we have professional researchers who can be detached and objective? The answer to this is that certainly people can and do fool themselves, but we find that they can also develop their attention so they can look at their beliefs and theories critically and, in this way, improve the quality of their claims to knowing. We call this 'critical subjectivity'; it means that we don't have to throw away our living knowledge in the search for objectivity but are able to build on it and develop it.

We have developed a number of procedures that can be part of a co-operative inquiry and which can help improve the quality of knowing. These are some of them.

Research cycling. It should be already clear that co-operative inquiry involves going through the four phases of inquiry several times, cycling between action and reflection, looking at experience from different angles, developing different ideas, trying different ways of behaving. The health visitors went through four or five cycles as the experimented with different ways of relating to their clients. Research cycling can be convergent, in which case the co-researchers look several times at the same issue, maybe looking each time in more detail; or cycling can be divergent, as co-researchers decide to look at different issues on successive cycles. Many

variations of convergence and divergence are possible in the course of an inquiry. It is up to the group to decide which one is appropriate for each piece of research.

Balance of action and reflection. Too much time in reflection is just armchair theorizing; too much time in action is mere activism. But it may be important, particularly in the early stages, to spend considerable time reflecting in order to gather together experience; and it may be important later to concentrate on trying out different actions to see how they work. Each inquiry group needs to find its own balance between action and reflection, depending on the topic being explored.

Developing critical attention. Co-researchers need to develop the ability to look at their experience with affectionate curiosity with the intention of understanding it better. They need not to be so attached to what they have been doing that they cannot be look at it critically. The process of research cycling is a discipline which helps people develop this ability. As the group matures it may be helpful to use constructive challenge in order to hone people's critical attention. For example, in the Devil's Advocate procedure each person takes a turn in saying what they believe they have discovered, and other group members challenge their statements, trying to find other explanations for their claims, or evidence which shows their claims are not based in experience.

Authentic collaboration. It is really important that members of a co-operative inquiry group develop ways of working which are collaborative. You can't really call it co-operative inquiry if one or two people dominate the group, or if some voices are left out altogether. This doesn't mean that everyone has to have exactly the same role: it may be that one person in the group has more knowledge of the subject, another knows more about the inquiry method. But it does mean that specialist knowledge is used in the service of the group. In order to develop equal contribution within a group it may be useful to rotate formal leadership round the group; to have 'rounds' in which everyone can have a say about the topic being discussed while the

rest listen; and regular review periods where all group members can say how they feel about the way the group is working. (It is also important to note that there may be people outside the inquiry group who are affected by what it does; while they cannot be full co- researchers, they too should be approached in the spirit of cooperation and dialogue.)

Dealing with distress. Co-operative inquiry can be an upsetting business. If the co- researchers are really willing to examine their lives and their experience in depth and in detail, it is likely that they will uncover things they have been avoiding looking at and aspects of their life with which they are uncomfortable. Indeed, many inquiry groups are set up to explore these kinds of issues. So, the group must be willing to address emotional distress openly when it arrives: to allow the upset persons the healing of self-expression, which may involve the release of grief, anger or fear. Further, it may well be right for a group to spend time identifying the emotional disturbances within the group which have not yet been expressed and providing space for this to happen. If the group does not pay attention to distress management, it is likely that the findings will be distorted by the buried emotions.

Chaos and order. Clearly co-operative inquiry can be seen as an orderly process of moving through cycles of action and reflection, taking account of experience in one cycle and applying it to the next. And so it is. But co-operative inquiry is also about intuitive discovery, happenstance and synchronicity. It is sometimes about throwing all caution to the winds in a wild experiment. The best inquiry groups find a balance between chaos and order. If the group is really going to be open, adventurous and innovative, to put all at risk to reach out for the truth beyond fear and collusion, then once the inquiry is well under way, divergence of thought and expression is likely to descend into confusion, uncertainty, ambiguity, disorder, and perhaps chaos, with most if not all co-researchers feeling lost to a greater or lesser degree. There can be no guarantee that chaos will occur; certainly one cannot plan it. The key validity issue is to be prepared for it, to be able to

tolerate it, to go with the confusion; not to let anxiety press for premature order, but to wait until there's a real sense of creative resolution.

Practical issues in setting up an inquiry group

Initiation. Most inquiry group are initiated by one or two people who have enthusiasm for an idea they wish to explore. They are quite often engaged on a research degree and are attracted to co-operative inquiry as a means of doing research; but they might just as well be members of an interest group - a patient's group, a women or minority person's group, a professional interest group - who see that co-operative inquiry might be a way of moving forward their interests.

Establishing a group. The initiators first task is to gather together a group of people who will be interested in joining the project. Sometimes the group is self-evidently formed, but more often it is recruited by some form of circular letter: for example, the black social worked mentioned above invited social work managers, practitioners and students to a meeting to discuss mutual interests and propose the establishment of inquiry groups. Groups of up to twelve persons can work well. Below six is a little too small and lacks variety of experience; above twelve needs time and maybe professional facilitation to manage.

Contracting. This is possibly the most important aspect of the establishment of a group: it is really important that as far as it is possible people have an opportunity to define the inquiry agenda and establish the process of the group. But this does not mean that they have to start from a blank sheet: usually the initiators put forward some proposal in a letter inviting people to a meeting to discuss the possible formation of a group. The meeting can explore the following agenda:

Welcome and introductions, helping people feel at home

Introduction by initiators: what we are interested in researching

People discuss what they have heard informally in pairs, followed by questions and discussion

Introduction to the process of co-operative inquiry

Pairs discussion followed by questions and discussion

Decision time: who wishes to join the group?

Practical discussion: dates, times, financial and other commitments.

It may be that I full discussion of items a) to e) is as far as a group can go in one meeting, and a second meeting is needed for decision making and practical arrangements.

Devising an overall research plan. Most groups agree to a programme of meetings arranged so there is sufficient time for cycles of action and reflection. A group wishing to explore activities that are contained within the group, such as meditation skills, may simply meet for a weekend workshop which will include several short cycles of practice and reflection. But a group which involves action in the external world will need to arrange long cycles of action and reflection with sufficient time for practical activity. The holistic doctors group met to reflect for a long weekend after every six weeks of action on the job. The health visitors for an afternoon every three weeks or so. An inquiry into interpersonal skill met for a weekend workshop at the home of two of the participants and then for a long afternoon and evening every month to six weeks, finishing with another residential weekend workshop.

Roles. It is helpful to agree early on how roles will be distributed. If the initiator is also to be group facilitator that should be made clear. It may be helpful to identify who has skills in group facilitation, inquiry facilitation, management of differences, working with distress, and so on and share out roles appropriately. Decide if you wish to be fully democratic and rotate leadership, or if you would prefer one or two people to facilitate on behalf of the group. And so on.

Ground rules. You may wish to agree ground rules, particularly to preserve confidences within the group.

Writing. It is helpful to decide who is the audience for your research early on. Is it just for yourselves, or do you wish to influence some outside persons? If you want to produce a written report or article, it is worth discussing who will write it and on what basis. Do all members of the group have to see and agree it before it can be sent out? Or is it acceptable for one or two people to write their own report based on the group experience. We have found it helpful to adopt the rule that anyone can write whatever they like about the group, so long as they state clearly who is the author and whether other group members have seen and approved the text.

Appendix 9 A summary of the first meeting decisions and the overall plan

(Reason, 1988, pp. 22-28 and 183- 197).

Membership:

There were 15 people in the inquiry group, with considerable experience in Christian ministry, with responsibilities of either a church pastor or pastoral responsibilities. Overall, the participants knew each other and have attended a mental health training course.

I invited the participants through invitation letters and recruitment through a workshop facilitated by me.

Discussions: the initial focus was on the issues below:

- Did our ministerial formation and training include a module on mental healthcare?
- How are we meeting congregant's mental health needs? How have you met those needs?
- What difficulties do you encounter working with a congregant with a mental health difficulty?

After many discussions, the inquiry group was formed and set out working rules when we agreed to work together—two separate inquiry groups formed in December 2016. We decided to work together for 3 hours for three more inquiry sessions.

The summary points of roles are:

- Participant to present short stories or vignettes of mental issues they have worked with as our action for our reflecting cycle. I explained we would continue the process of the actions (reading the scenarios) and reflect until the group, united on something new or run out of time or something that allows us to stop the inquiry. We agreed that all vignettes were to be treated with respect and should receive equal discussions.

- To keep a journal throughout the project, to record any unique idea and new knowledge. Participants agreed that journal keeping should be optional as some felt unable to keep a journal.
- We agreed to select a participant to write on a flipchart the consensus decisions or highlight critical or interesting points for further reflection.
- The criteria for deciding consensus was on the agreement of two or more participants with the same or similar impression.
- The research initiator to provide leadership in the overall facilitation. To draw out exciting themes to include vital and controversial information.
- The facilitator to lead a process if a participant Shows any emotional distress.
- The researcher is responsible for audio recording and its safekeeping
- All to ensure and to provide a safe environment for everyone.

Writing the report

In Doctoral research, the primal researcher (doctoral student) will write his view of the co-operative inquiry and his draft and discussed the finding with the group. Reason (1988) suggest the importance of talking to interested and experienced people who are not too heavily involved. And to have the group to act as a critical friend (Torbert, 1976 cited in Reason, 1988). My supervisors also supervised my work and suggested correction and amendment, which I have incorporated into the report.

Ending:

I thanked everyone for helping with the inquiry by sharing their experience and contributing to the research. We talked about our hopes and aspirations, and members felt it was a worthwhile project and enjoyed every bit of it. We wished each other well, and all were wishing me well. Participants requested a copy of the report. We said our proper goodbyes and ended the inquiry group with a well-deserved refreshment.

Appendix 10 Additional vignettes (A & B)

A. Angelina: I do not know what else to do with this one!

This vignette is about A middle-age congregants with mental illness using the NHS mental health services. She has not disclosed her diagnoses. Her behaviour is erratic and quite unpredictable. This person is verbally attacking, and she has caused a disable club to close down because of her aggressiveness, follows and chases church members and shouts absurdity at them on the street. We had to call in the police at some point, is there another way? Most church members are afraid of her; some have stopped coming to church, and others moved out of the area because of her behaviour.

This member has caused fear amongst so many church members, and I am trying to deal with that.

What is frightening about her, She comes across as loving obviously, but she has some problem. This congregant needs more help than I could give her. I do not feel equipped to deal with this situation. Practically, what I am doing is not working. Pastorally, I can support her by listening and challenging her behaviour. What else to do with this one?

Venetta's vignette:

B. Kate (not her real name)

Kate is a church member who sees demons and angels that talk to her. She was diagnosed with major depressive disorder and treated with medication. Kate attended our deliverance prayer meetings for these problems. Eventually, the deliverance minister told her to stop taking her medication and trust in the miraculous healing power of Christ. However, when she stops taking her medication, her experience returns. After attending many deliverance services, the family and deliverance team tell her that she is not holy and not demonstrating enough faith for her cure.

Reflection:

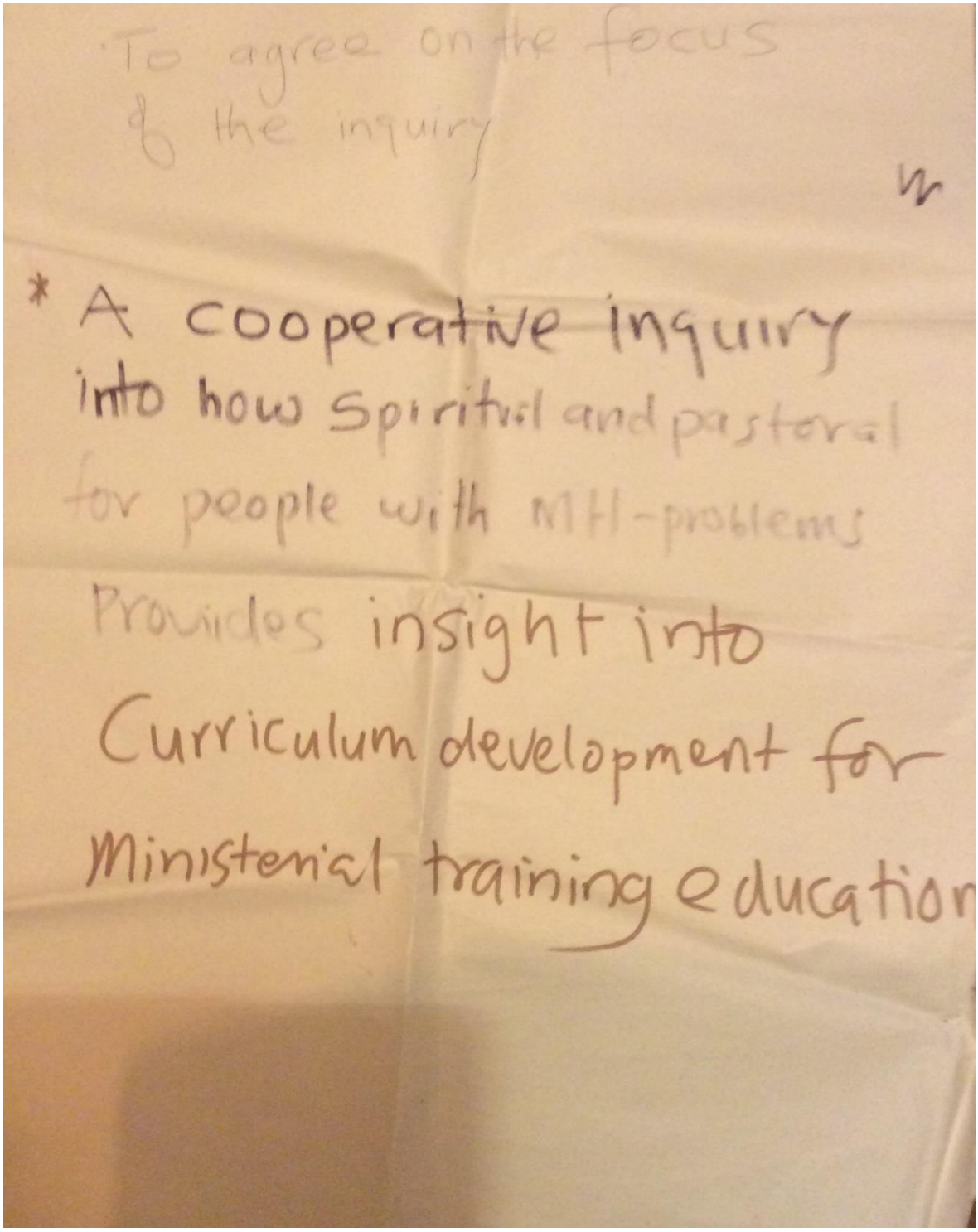
This vignette triggered a participant to disclose how her church treated her through her depression. I have used this participant reflection of this in the thesis

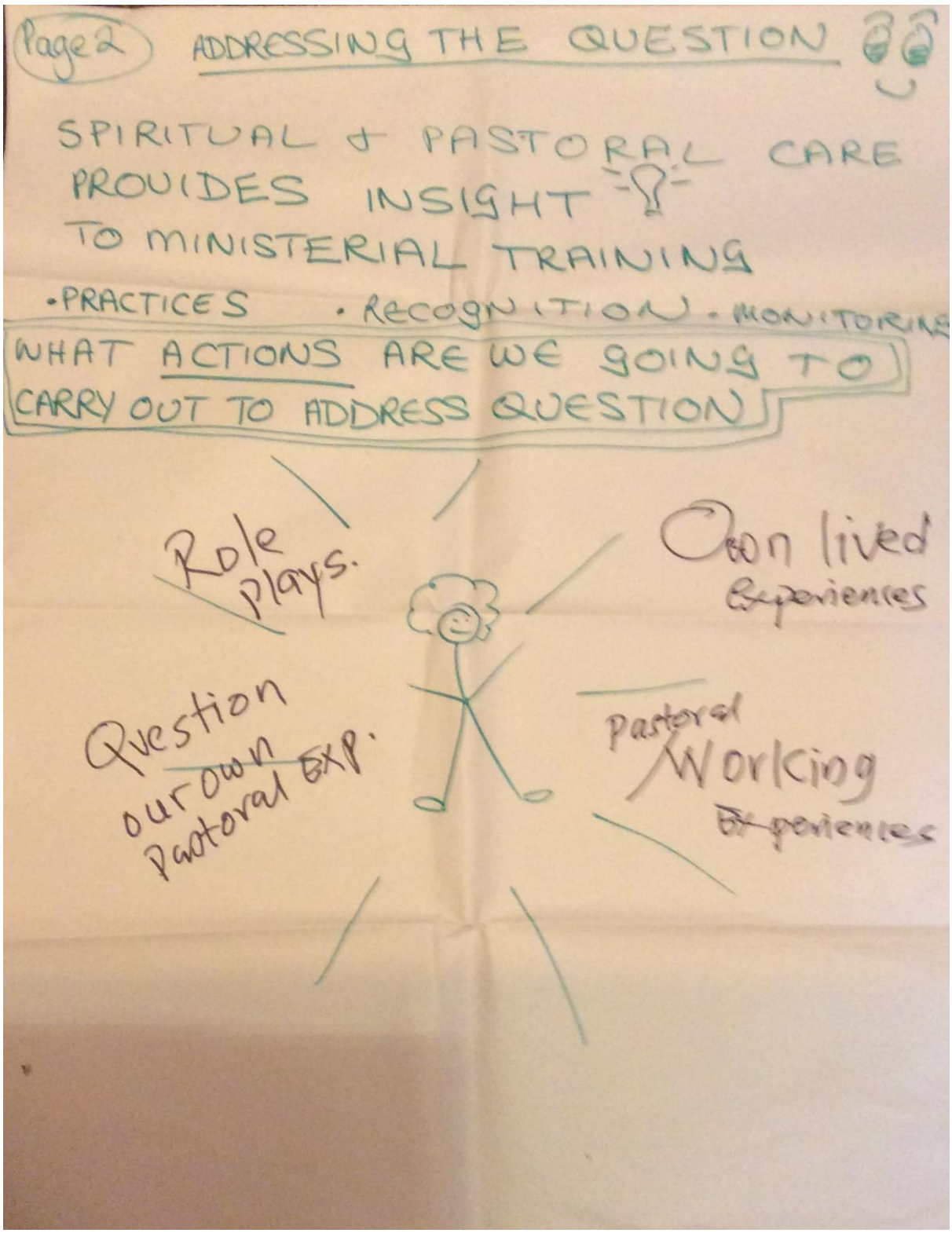
Appendix 11 Assigning Anchor Codes to Research Question

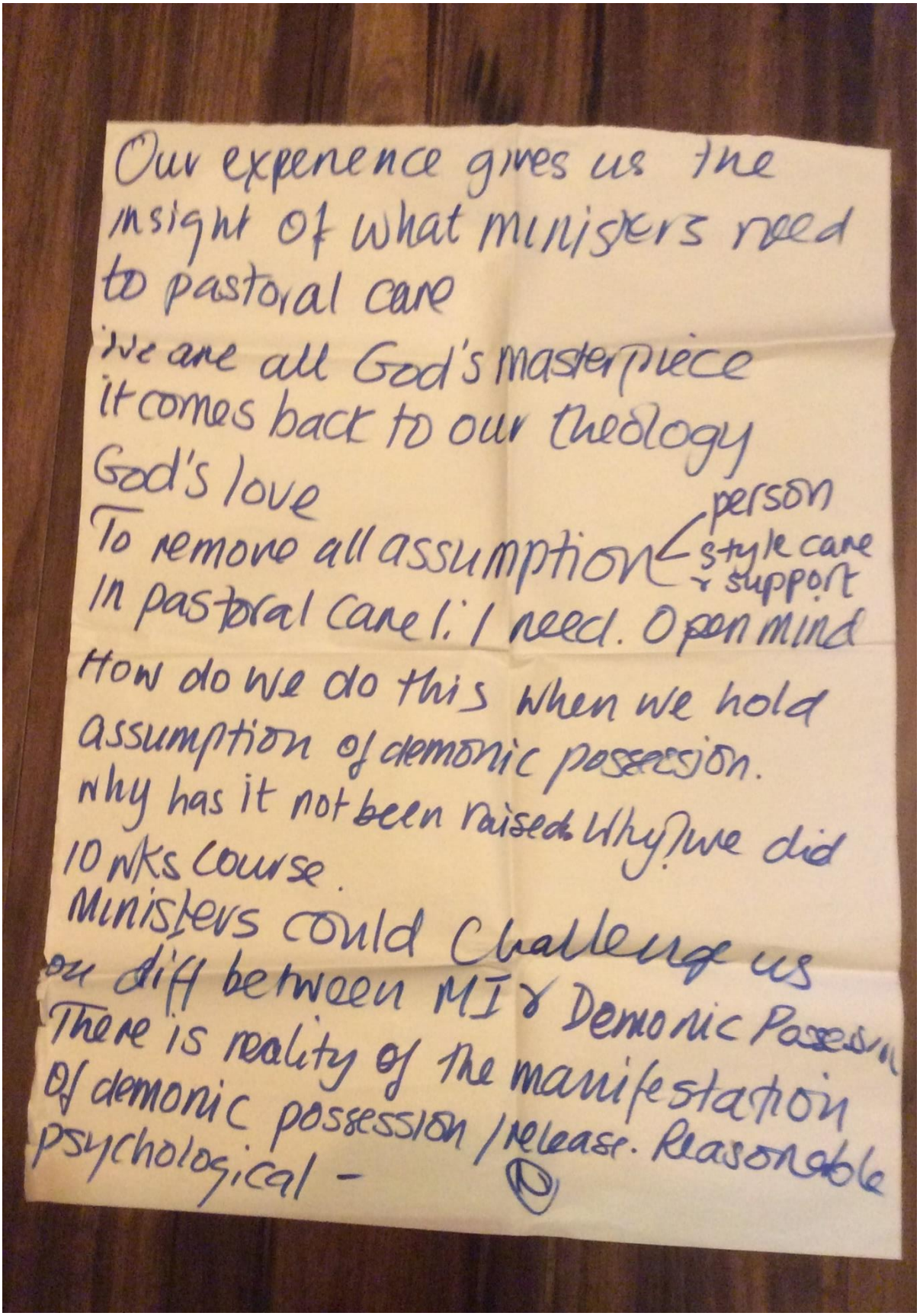
Please see Supplementary Portfolio Document.

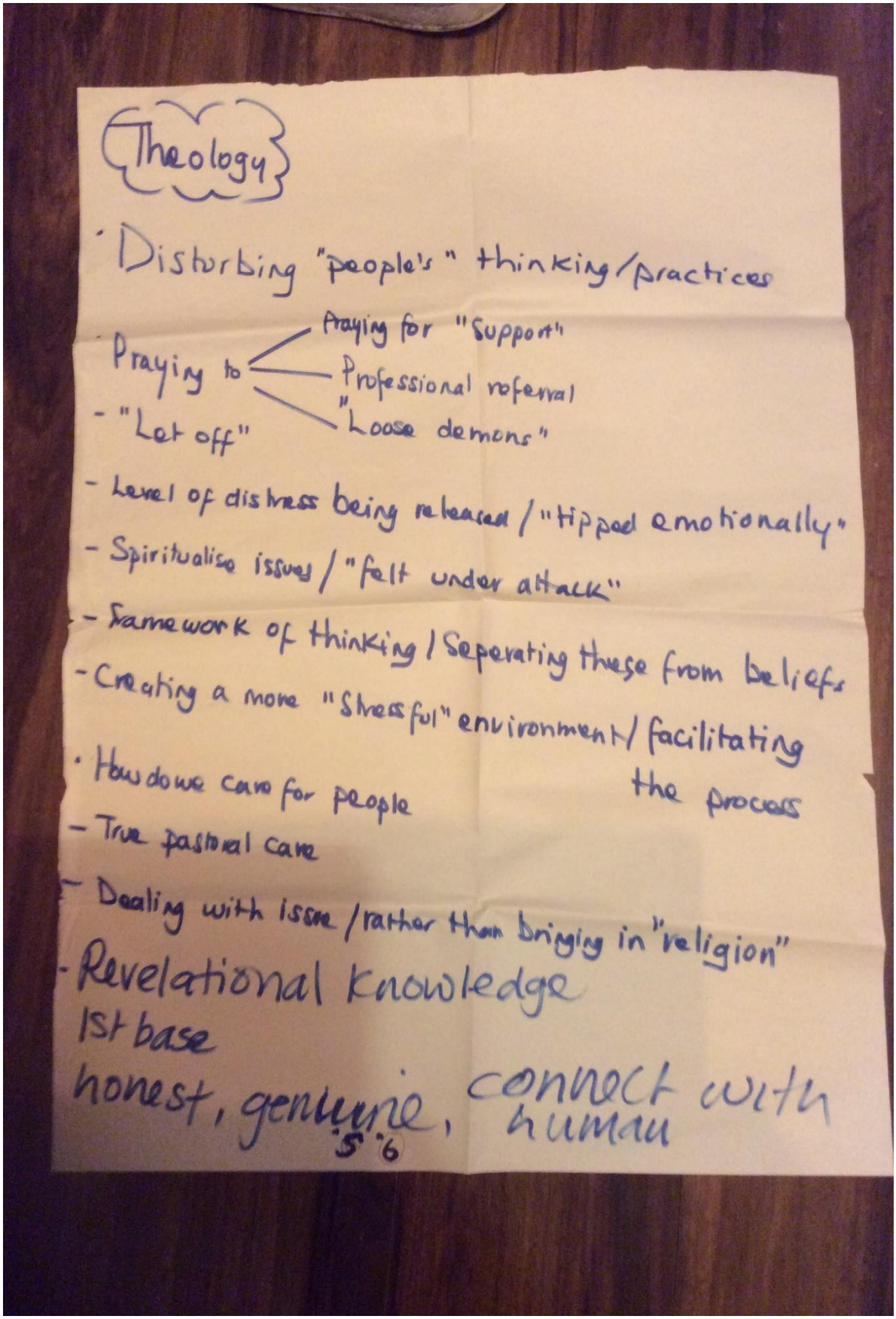
Appendix 11a Samples of flip-chart summary

Southeast 2

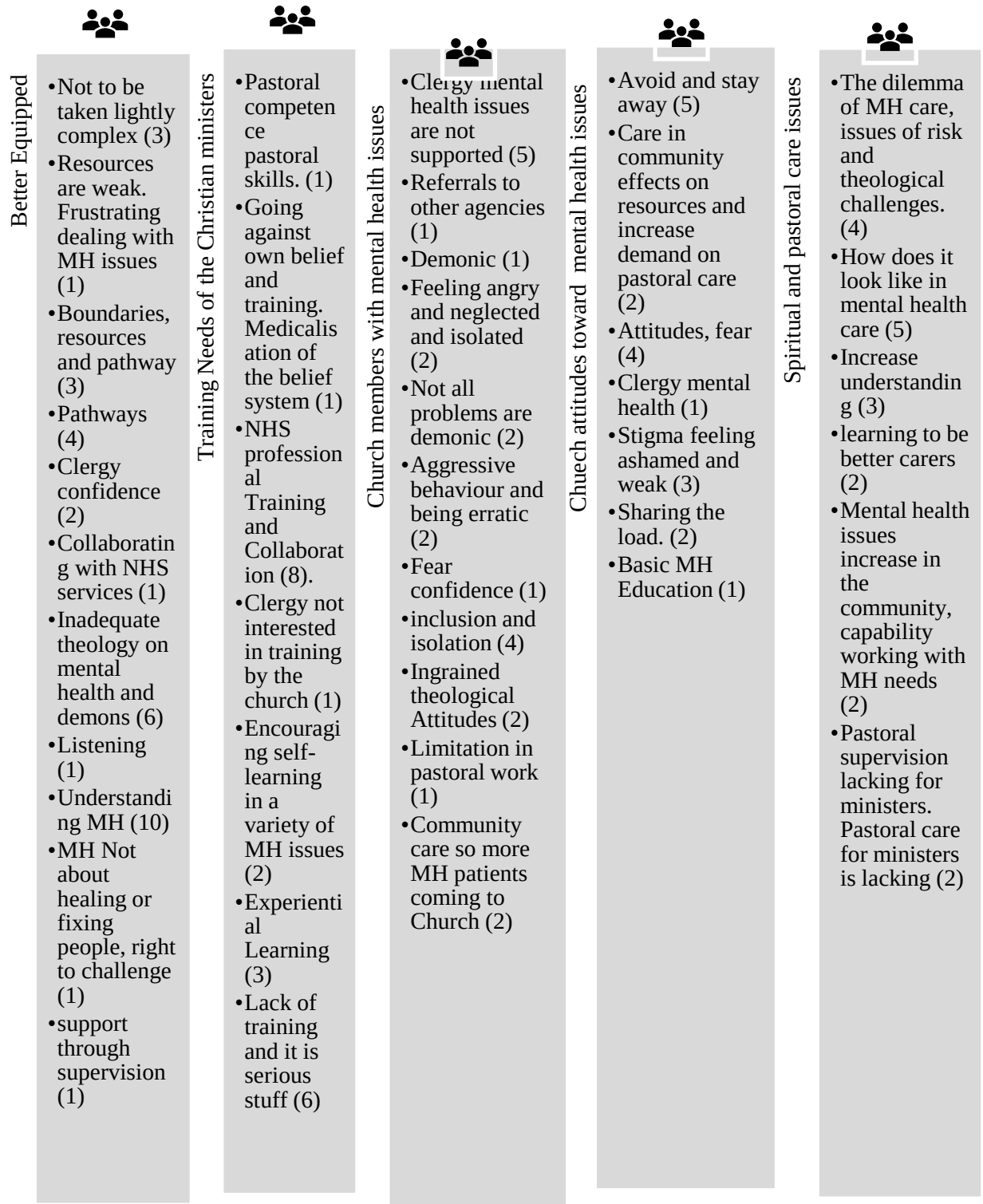


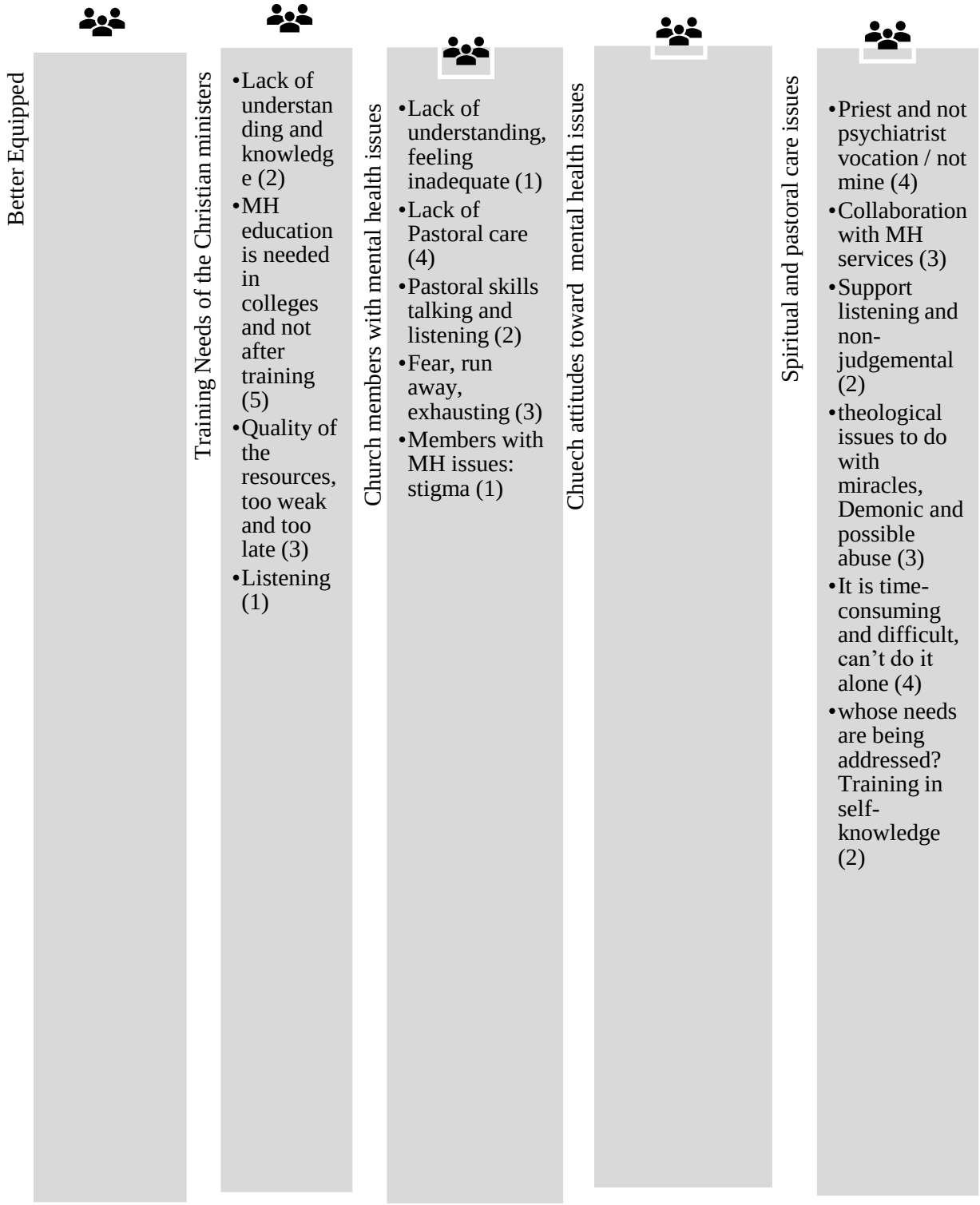

Page 2
ADDRESSING THE QUESTION
SPIRITUAL & PASTORAL CARE PROVIDES INSIGHT TO MINISTERIAL TRAINING
•PRACTICES
• RECOGNITION
• MONITORING
WHAT ACTIONS ARE WE GOING TO CARRY OUT TO ADDRESS QUESTION
Role plays.
Own lived Experiences
Question our own Pastoral Exp.
Pastoral Working Experiences


Our experience gives us the insight of what ministers need to pastoral care
We are all God's masterpiece
it comes back to our theology
God's love
To remove all assumption
person style care support
In pastoral care i.e. I need. Open mind
How do we do this when we hold assumption of demonic possession.
why has it not been raised. Why? we did 10 wks course.
Ministers could challenge us
on diff between MI & Demonic Possession
There is reality of the manifestation of demonic possession / release. Reasonable
psychological -

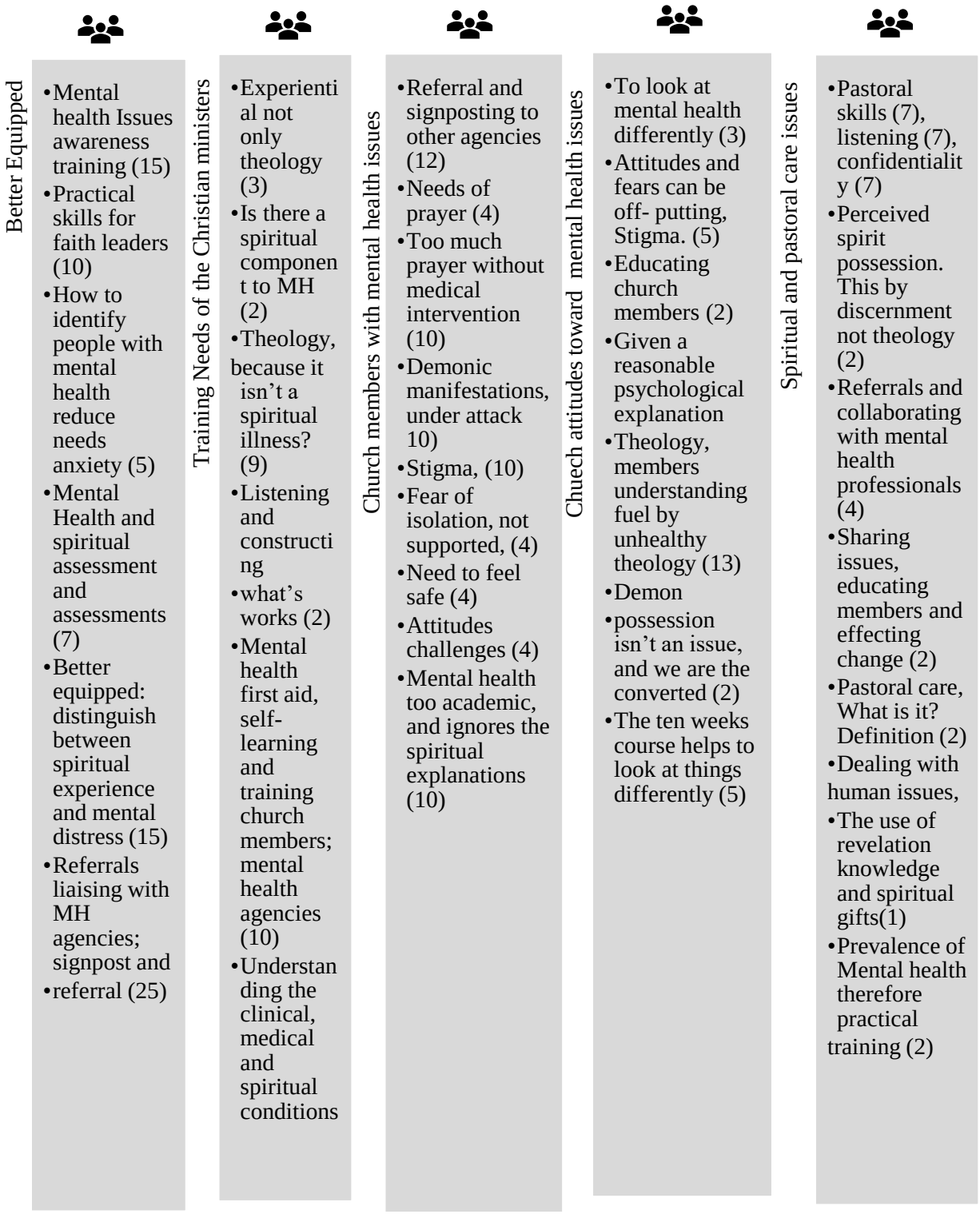

Theology
Disturbing "people's" thinking/practices
Praying to
Praying for "support"
Professional referral
"Loose demons"
"Let off"
Level of distress being released / "tipped emotionally"
Spiritualise issues / "felt under attack"
Framework of thinking / Seperating these from beliefs
Creating a more "Stressful" environment / facilitating the process
How do we care for people
True pastoral care
Dealing with issue / rather than bringing in "religion"
Revelational knowledge
1st base
honest, genuine, connect with human
5'6

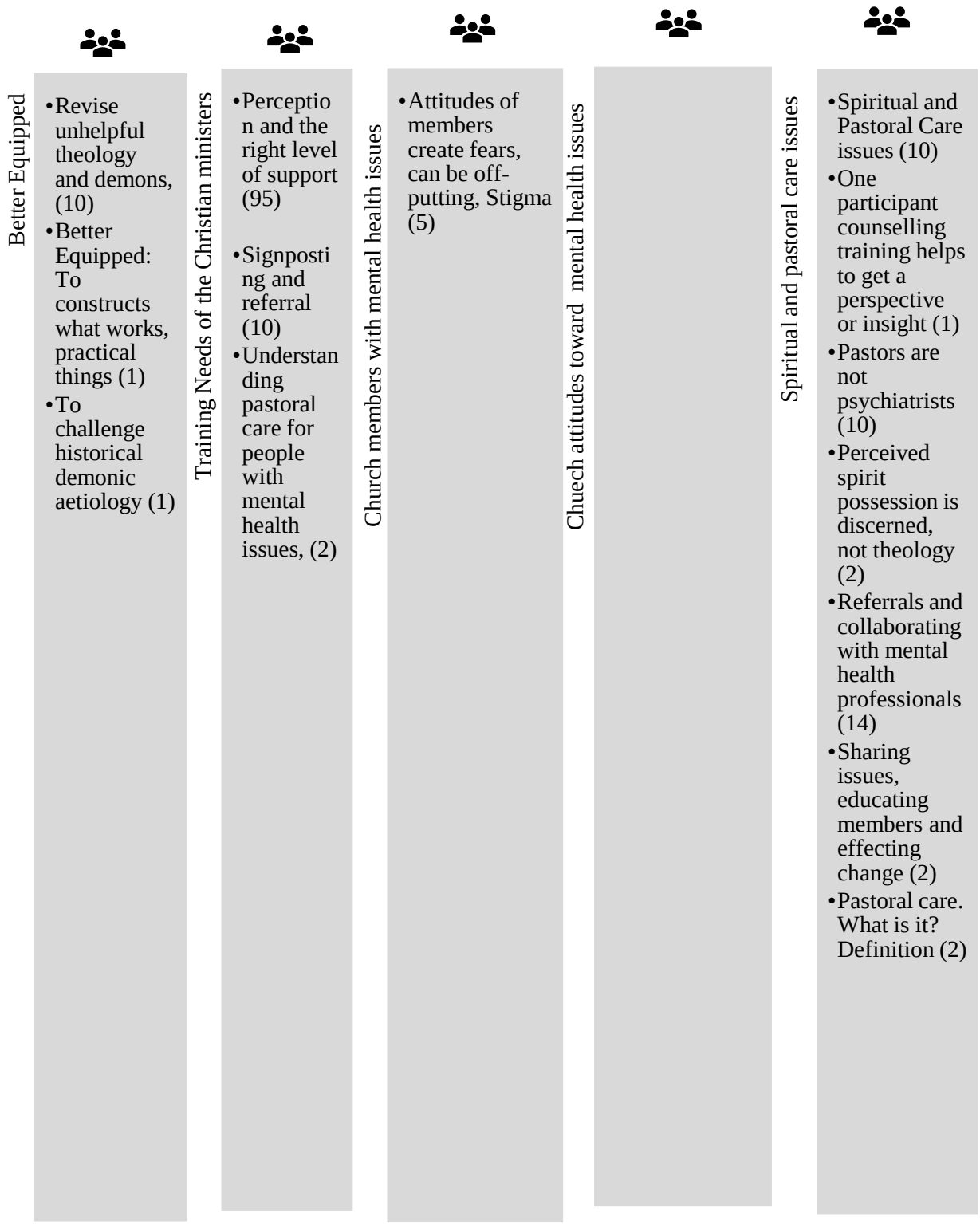
Appendix 12 Southeast1 phase 2 coding *(149 codes generated)*



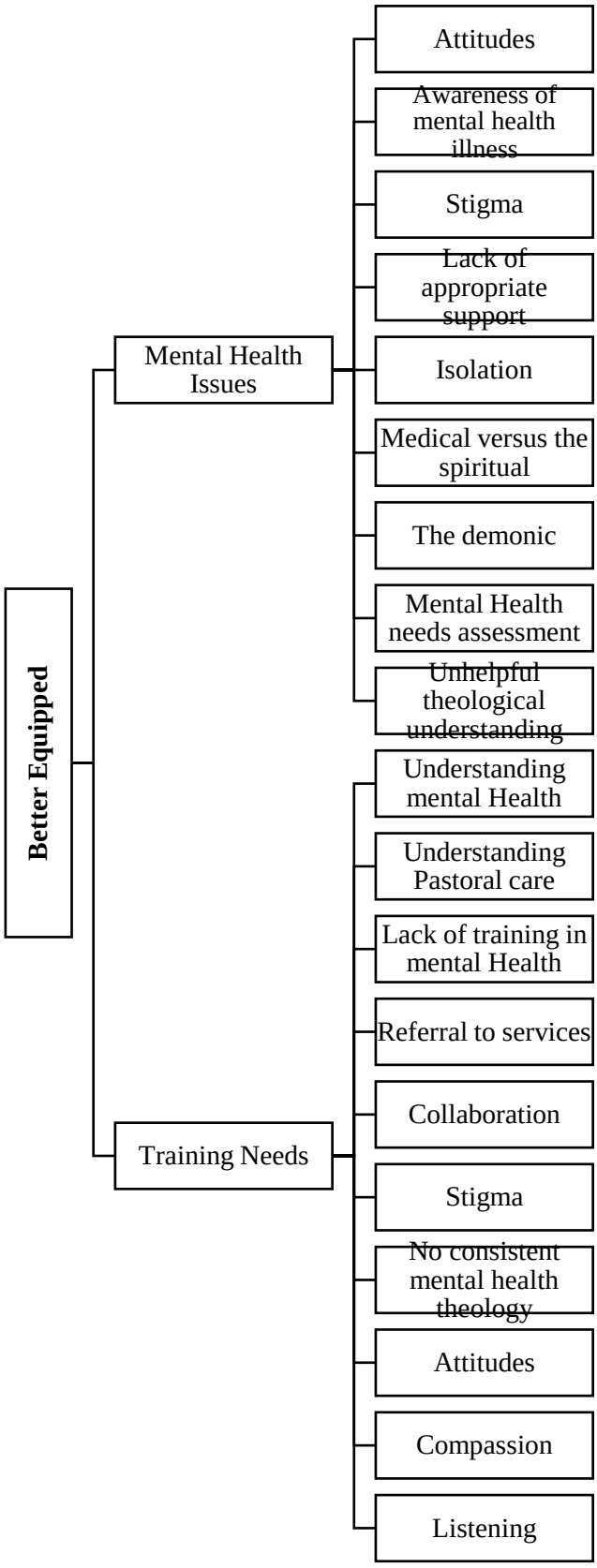

Better Equipped
Training Needs of the Christian ministers
•Lack of understanding and knowledge (2)
•MH education is needed in colleges and not after training (5)
•Quality of the resources, too weak and too late (3)
•Listening (1)
Church members with mental health issues
•Lack of understanding, feeling inadequate (1)
•Lack of Pastoral care (4)
•Pastoral skills talking and listening (2)
•Fear, run away, exhausting (3)
•Members with MH issues: stigma (1)
Chuech attitudes toward mental health issues
Spiritual and pastoral care issues
•Priest and not psychiatrist vocation / not mine (4)
•Collaboration with MH services (3)
•Support listening and non-judgemental (2)
•theological issues to do with miracles, Demonic and possible abuse (3)
•It is time-consuming and difficult, can't do it alone (4)
•whose needs are being addressed? Training in self-knowledge (2)

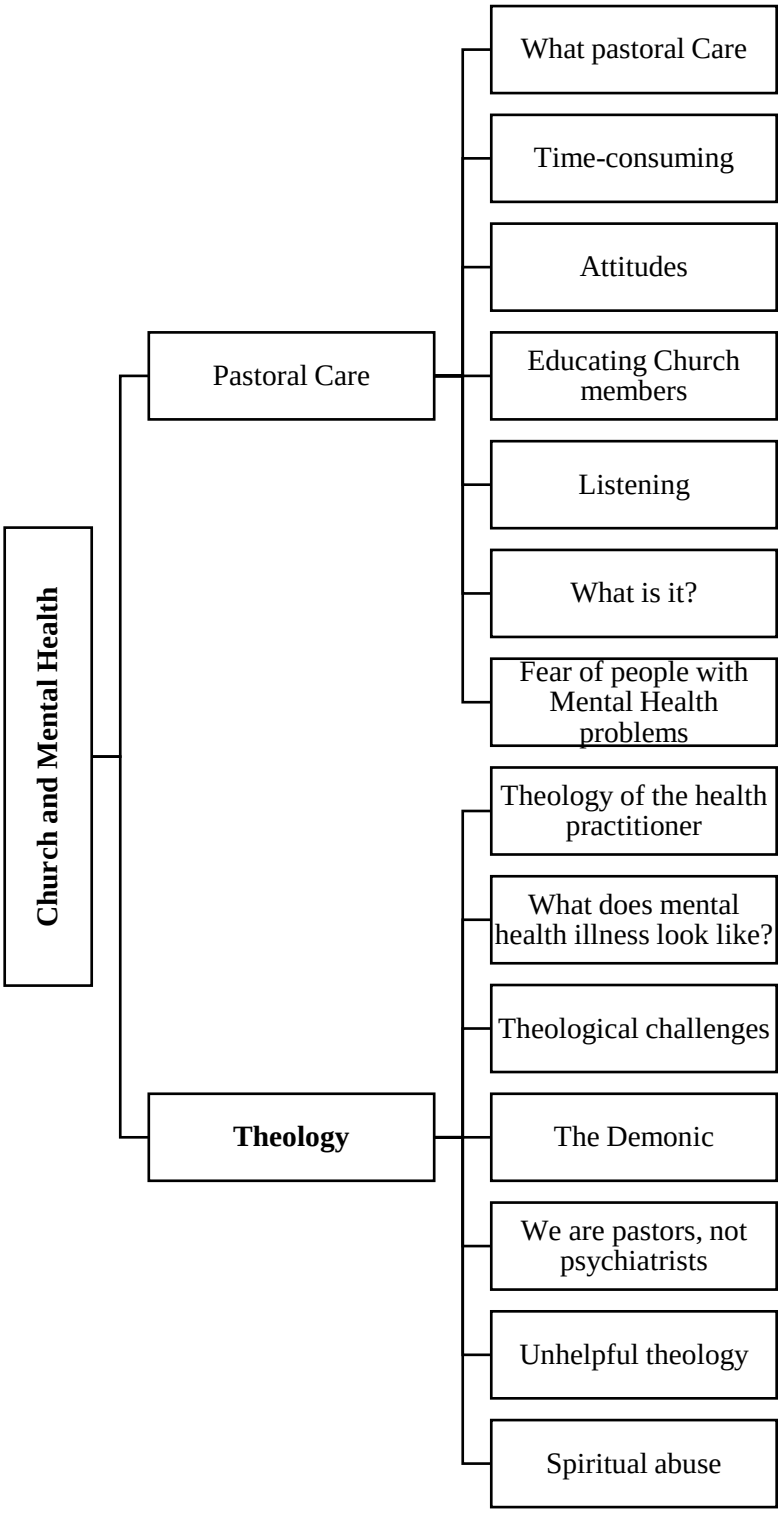
Appendix 13 Southeast 2 phase 2 coding *(398 codes generated)*




Better Equipped
•Revise unhelpful theology and demons, (10)
•Better Equipped: To constructs what works, practical things (1)
•To challenge historical demonic aetiology (1)
Training Needs of the Christian ministers
•Perception and the right level of support (95)
•Signposting and referral (10)
•Understanding pastoral care for people with mental health issues, (2)
Church members with mental health issues
•Attitudes of members create fears, can be off-putting, Stigma (5)
Chuech attitudes toward mental health issues
Spiritual and pastoral care issues
•Spiritual and Pastoral Care issues (10)
•One participant counselling training helps to get a perspective or insight (1)
•Pastors are not psychiatrists (10)
•Perceived spirit possession is discerned, not theology (2)
•Referrals and collaborating with mental health professionals (14)
•Sharing issues, educating members and effecting change (2)
•Pastoral care. What is it? Definition (2)

Appendix 14 Southeast 1 & 2 thematic map of two dominant themes.



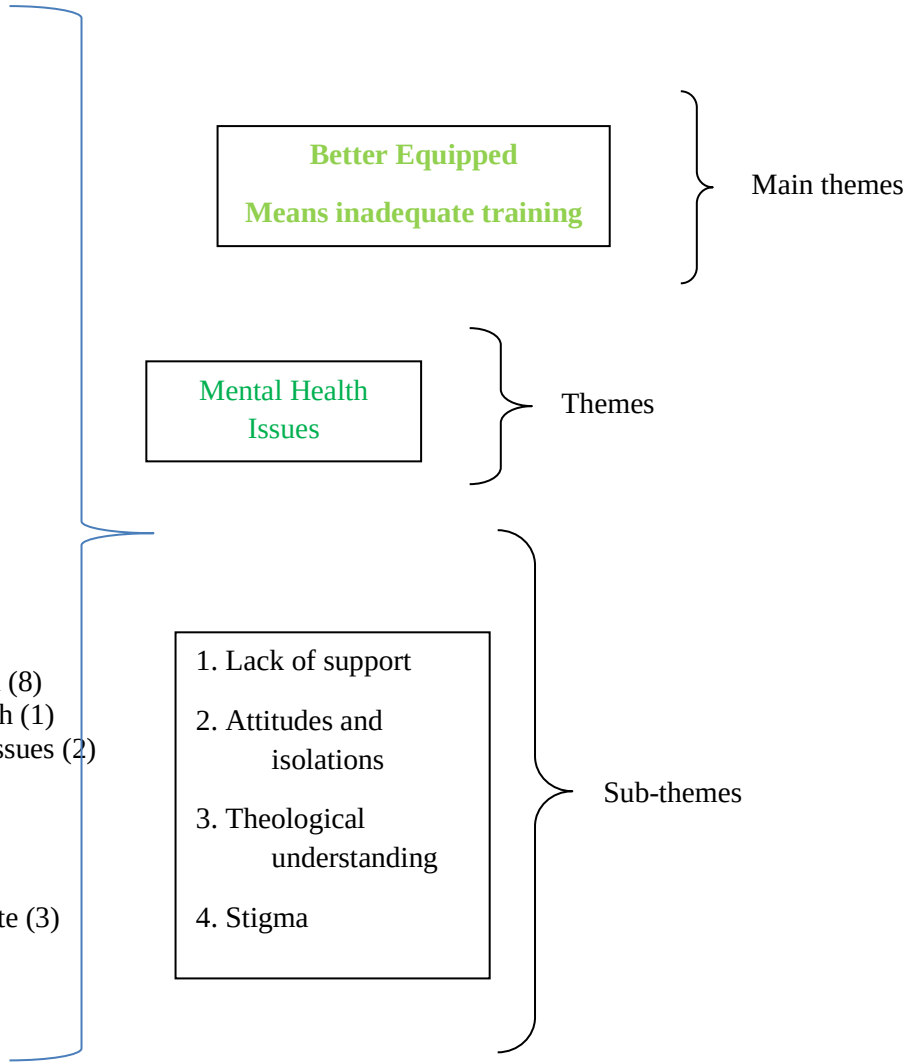

Church and Mental Health
Pastoral Care
What pastoral Care
Time-consuming
Attitudes
Educating Church members
Listening
What is it?
Fear of people with Mental Health problems
Theology
Theology of the health practitioner
What does mental health illness look like?
Theological challenges
The Demonic
We are pastors, not psychiatrists
Unhelpful theology
Spiritual abuse

Appendix 15 Generating the themes to address the research question

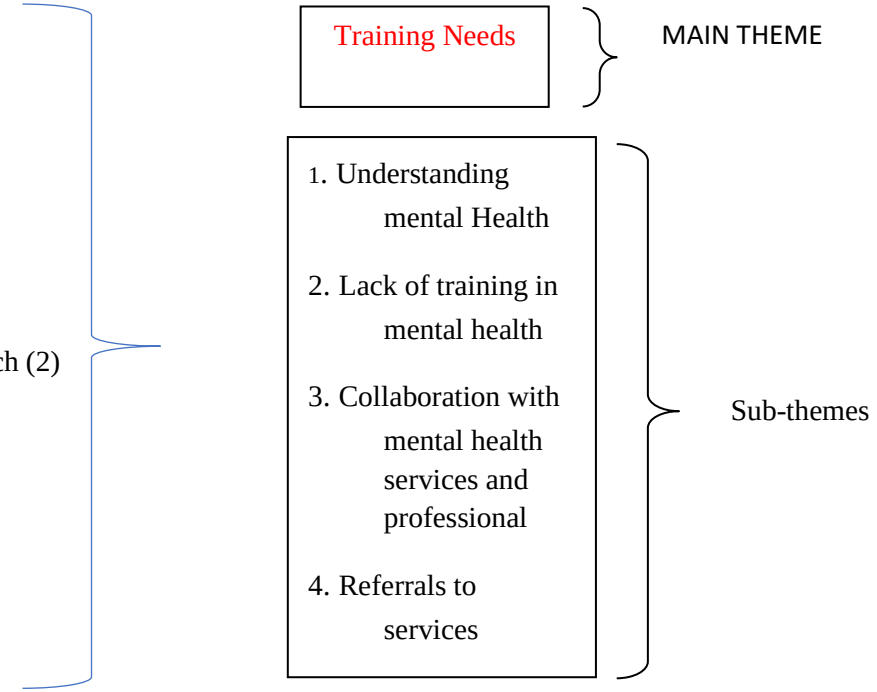
Anchor Codes Codes

1. Better Equipped: Not to be taken lightly complex (3)
2. Better Equipped: Resources are weak. Frustrating dealing with MH issues (1)
3. Better Equipped: Boundaries, resources and pathway (3)
4. Better Equipped: Pathways (4)
5. Better Equipped: Clergy confidence (2)
6. Better Equipped: Collaborating with NHS services (1)
7. Better Equipped: Inadequate theology on mental health and demons (6)
8. Better Equipped: Listening (1)
9. Better Equipped: MH understanding (10)
10. Better Equipped: not about healing or fixing people, Right to challenge (1)
11. Better Equipped: Referral where to go for help (9)
12. Better Equipped: Specialised support through supervision (1)

1. Mental health and training needs: Pastoral competent pastoral kills. (1)
2. Mental health and training needs: Going against your own belief and training/ Medicalisation of a belief system (1)
3. Mental health and training needs: NHS professional Training and Collaboration (8)
4. Mental health and training needs: Clergy not interested in training by the Church (1)
5. Mental health and training needs: Encouraging self-learning of variety of MH issues (2)
6. Mental health and training needs: Experiential Learning (3)
7. Mental health and training needs Lack of training, and it is serious stuff (6)
8. Mental health and training needs: Lack of understanding and knowledge (2)
9. Mental health and training needs: Needed in colleges and not after training (5)
10. Mental health and training needs: Quality of the resources, loo weak and too late (3)
11. Mental health and training needs: Training for all (2)
12. Mental health and training needs: Listening (1)



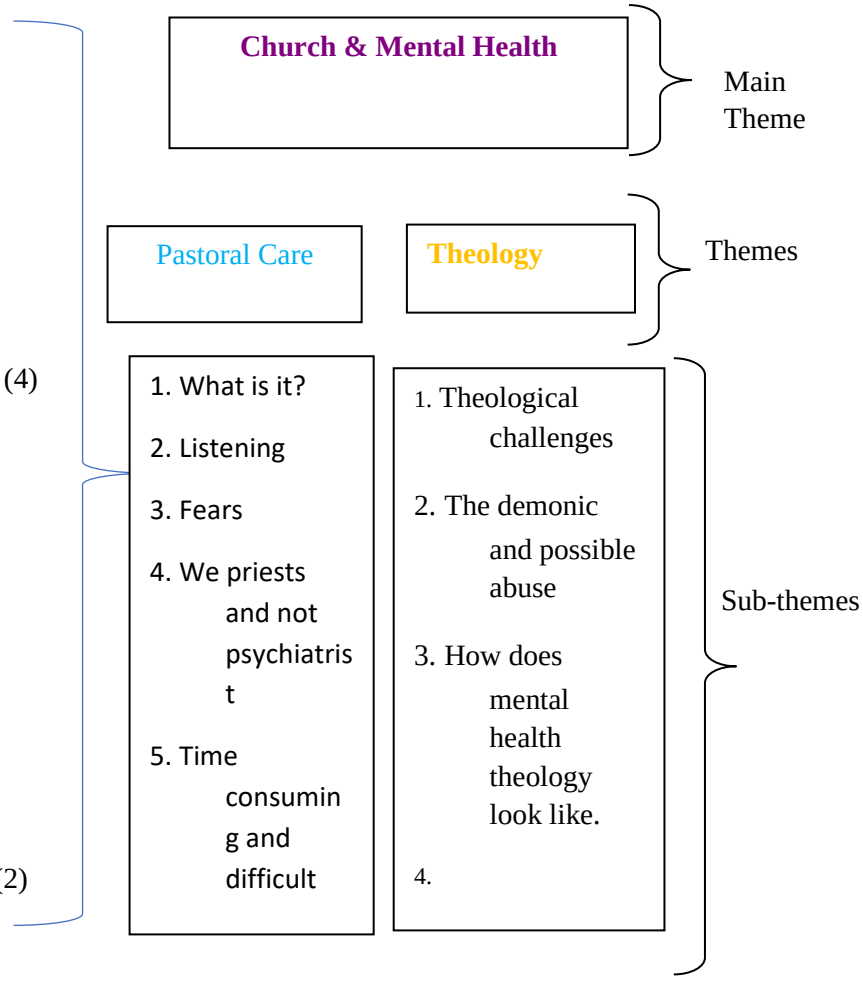
1. Member with MH Issues: Clergy mental health issues and not supported (5)
2. Member with MH issues: Referrals to other agencies (1)
3. Member with MH issues: Demonic (1)
4. Member with MH issues: Feeling angry and neglected and isolated (2)
5. Member with MH issues: Not all demonic (2)
6. Members with MH issues: Aggressive behaviour and being erratic (2)
7. Members with MH issues: Fear confidence (1)
8. Members with MH issues: inclusion and isolation (4)
9. Members with MH issues: Ingrained theological Attitudes (2)
10. Members with MH issues: Limitation in pastoral work (1)
11. Members with MH Issues: Community care so more MH patients coming to Church (2)
12. Members with MH issues: Lack of understanding, feeling inadequate (1)
13. Members with MH issues: Lack of Pastoral care (4)
14. Members with MH issues: Pastoral skills talking and listening (2)
15. Members with MH issues: Fear, run away, exhausting (3)
16. Members with MH issues: stigma (1)



Church and mental Health

1. Church and Mental Health: Avoid and stay away (5)
2. Church and Mental Health: Care in community effects on resources and increase demand on pastoral care (2)
3. Church and mental health: Attitudes, fear (4)
4. Church and mental health: Clergy mental health (1)
5. Church and Mental health: Stigma feeling ashamed and weak (3)
6. Church and Mental Health: Sharing the load. (2)
7. Church and Mental Health Basic MH Education (1)

1. Spiritual and Pastoral care: Dilemma of MH care issues of risk and theological challenges. (4)
2. Spiritual and Pastoral care: How does it look like in mental health care (5)
3. Spiritual and Pastoral Care: Increase understanding (3)
4. Spiritual and Pastoral care: learning to be better carers (2)
5. Spiritual and Pastoral care: Mental health issues increase in the community, capability working with MH needs (2)
6. Spiritual and pastoral care: Pastoral supervision lacking for ministers. Pastoral care for ministers lacking (2)
7. Spiritual and Pastoral Care: Priest and not psychiatrist vocation / not my(4)
8. Spiritual and Pastoral care: Collaboration with MH services (3)
9. Spiritual and Pastoral Care: Support listening and non-judgemental (2)
10. Spiritual and Pastoral care: Theological issues to do with miracles, Demonic and possible abuse (3)
11. Spiritual and Pastoral Care: Time consuming and difficult, cannot do it alone (4)
12. Spiritual and Pastoral care: whose needs are being addressed? Training in self-knowledge (2)

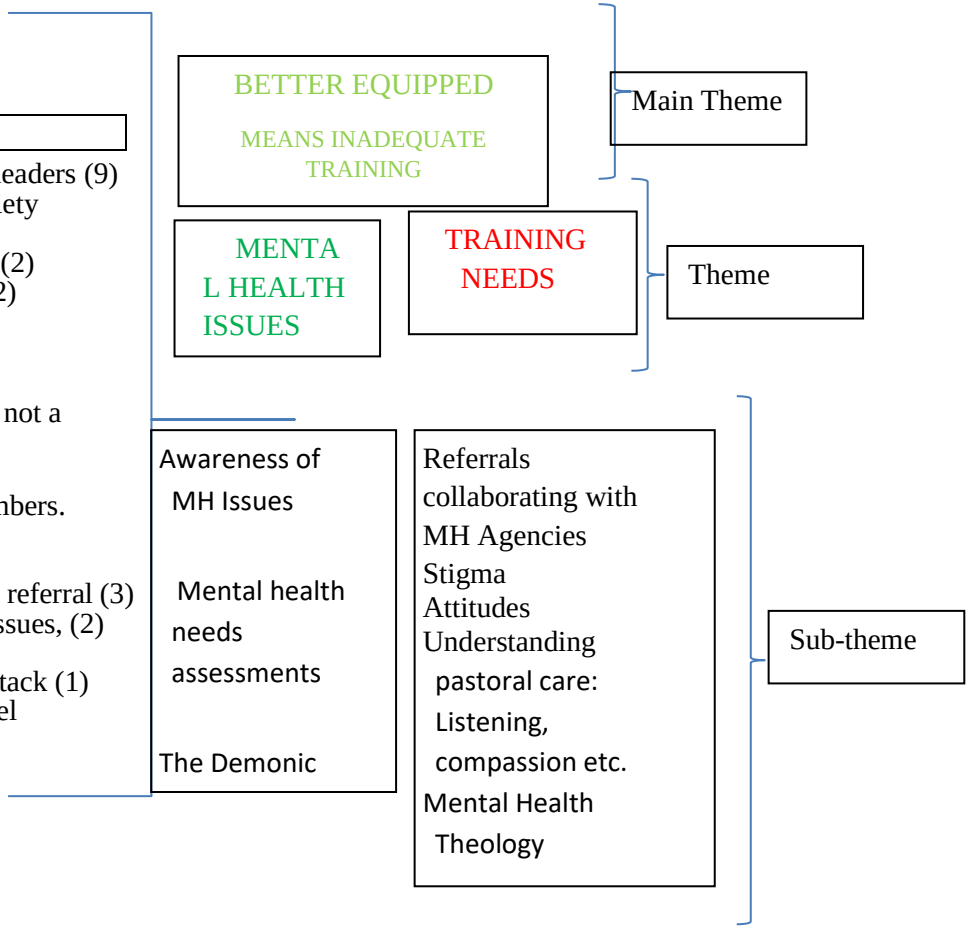


Southeast 2

Better Equipped

Anchor Codes	Codes

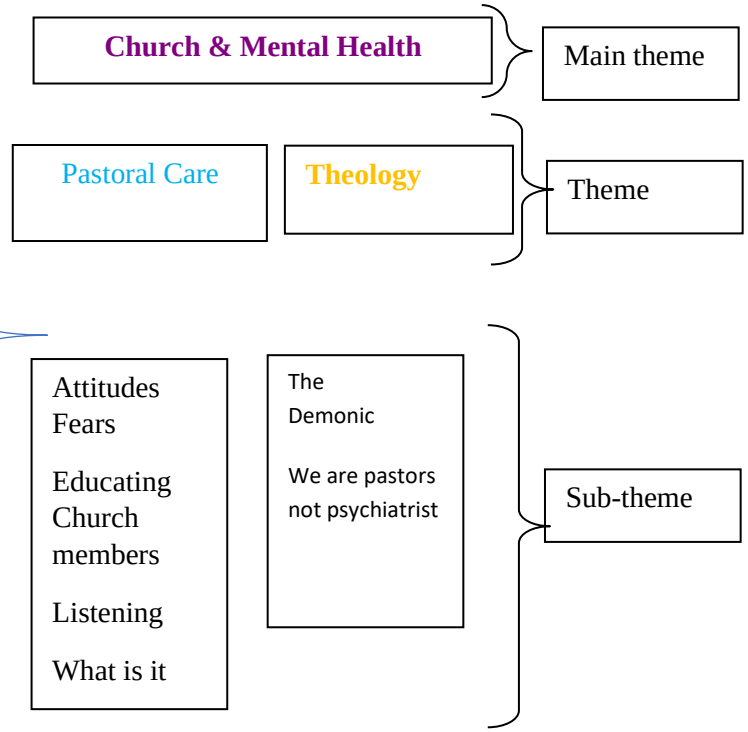
1. Better Equipped: Awareness of mental health issues, practical skills for faith leaders (9)
2. Better Equipped: how to identify people with mental health reduce needs anxiety and assessments (7)
3. Better equipped: distinguish between spiritual experience and mental distress (2)
4. Better Equipped: Referrals liaising with MH agencies; signpost and referral (2)
5. Better Equipped: Revise unhelpful theology and demons, (4)
6. Better Equipped: To constructs what works, practical things (1)
1. Training needs: Experiential not only theology (3)
2. Training Needs: Is there a spiritual component to MH Theology, because it is not a spiritual illness? (1)
3. Training Needs: Listening and constructing what's works (2)
4. Training Needs: Mental health first aid, self-learning and training church members. mental health agencies (2)
5. Training Needs: Understanding the clinical and spiritual
6. Training Needs: Perception and the right level of support and signposting and referral (3)
7. Training Needs: Understanding pastoral care for people with Mental Health Issues, (2)
1. Members and MH Issues: Referral and signposting to other agencies (2)
2. Members with MH Issues: Needs of prayer, demonic manifestations, under attack (1)
3. Members with MH Issues: Stigma, fear of isolation, not supported, need to feel safe attitudes challenges (4)
4. Members with MH Issues: Mental health too academic, need the spiritual (1)



Church and Mental Health

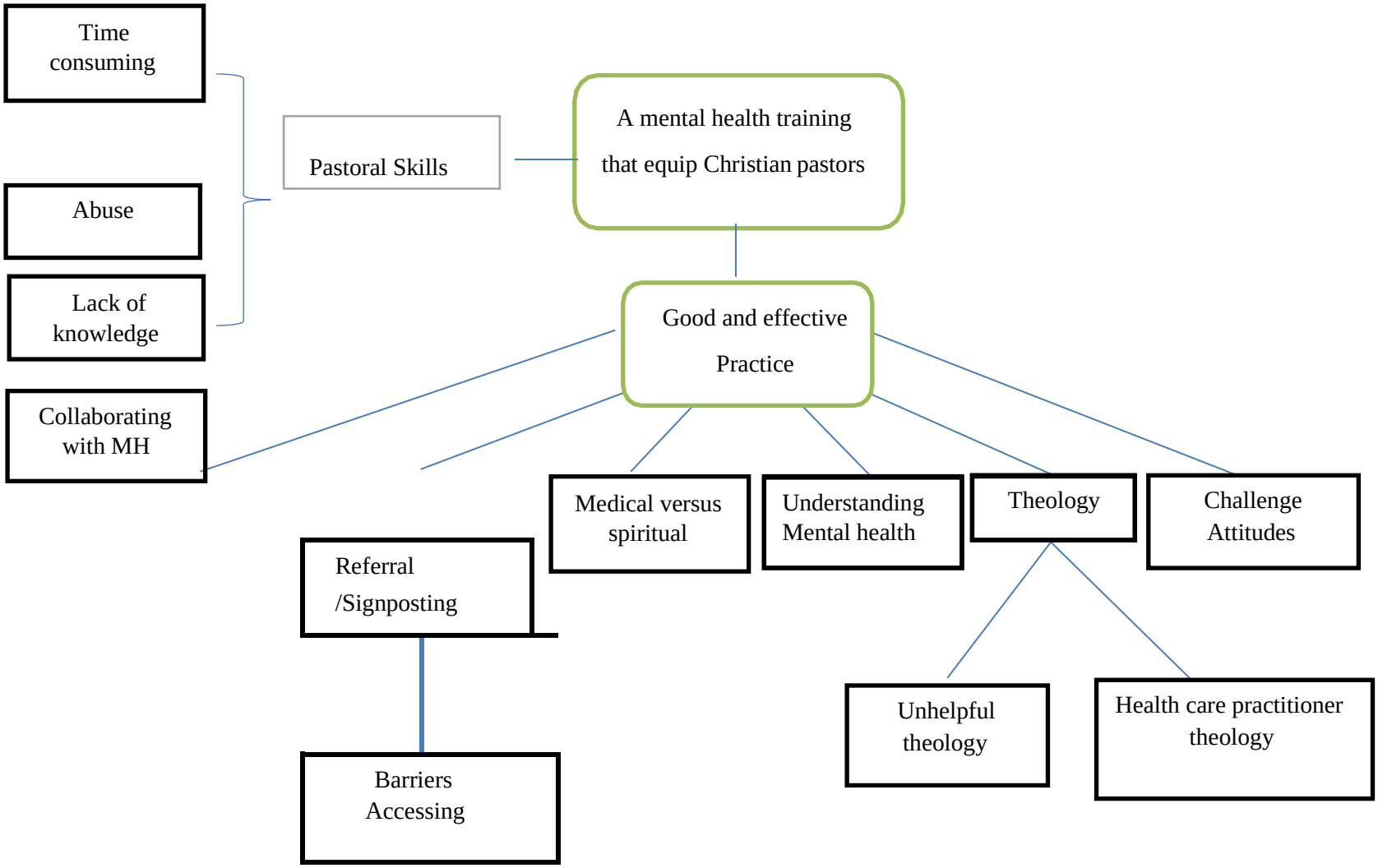
Anchor Codes	Codes

1. Church and Mental Health: Attitudes/fears can be off-putting, stigma. (5)
2. Church and Mental Health: Demon possession is not an issue; we are the converted. The 10-weeks course helps us to look at mental health differently (3)
3. Church and Mental health: Educating church members (2)
4. Church and Mental Health: Reasonable psychological explanations exist
5. Church and Mental Health: Theology, members understanding (3)
1. Spiritual and Pastoral care: Pastoral skills, listening, confidentiality (7)
2. Spiritual and pastoral care: Dealing with human issues, the use of revelation knowledge (1)
3. Spiritual and Pastoral Care: Mental health common, practical training (2)
4. Spiritual and Pastoral Care: My counselling training helps to get a perspective or insight
5. Spiritual and Pastoral Care: Pastors and not a psychiatrist (1)
6. Spiritual and Pastoral Care: perceived spirit possession. This by discernment not theology (2)
7. Spiritual and Pastoral Care: Referrals and collaborating with mental health professionals (4)
8. Spiritual and Pastoral Care: Sharing issues, educating members and effecting change (2)
9. Spiritual and Pastoral Care: What is it? Definition (2)

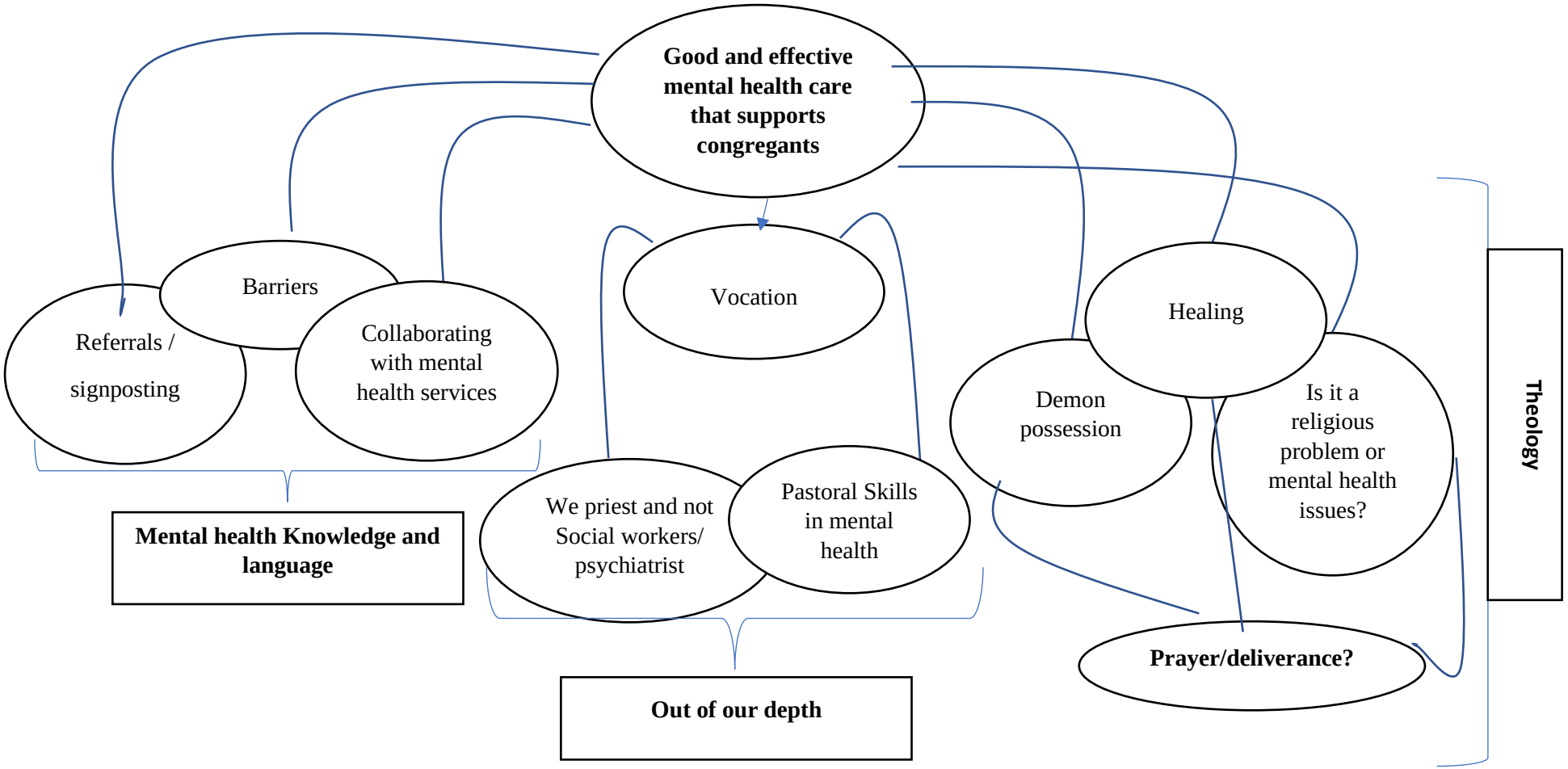


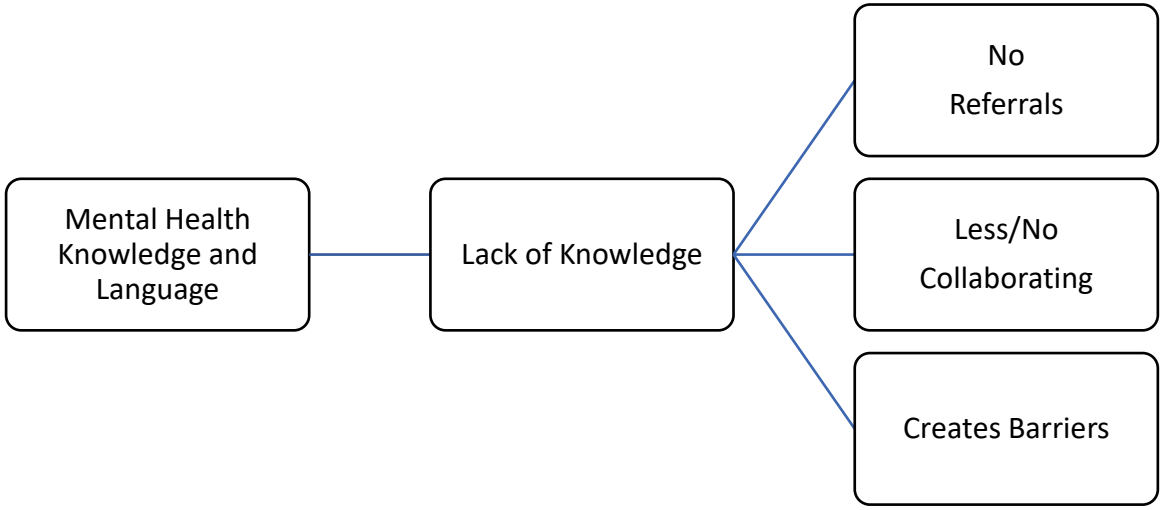
The two inquiry groups together to produce themes as follows in the table below.

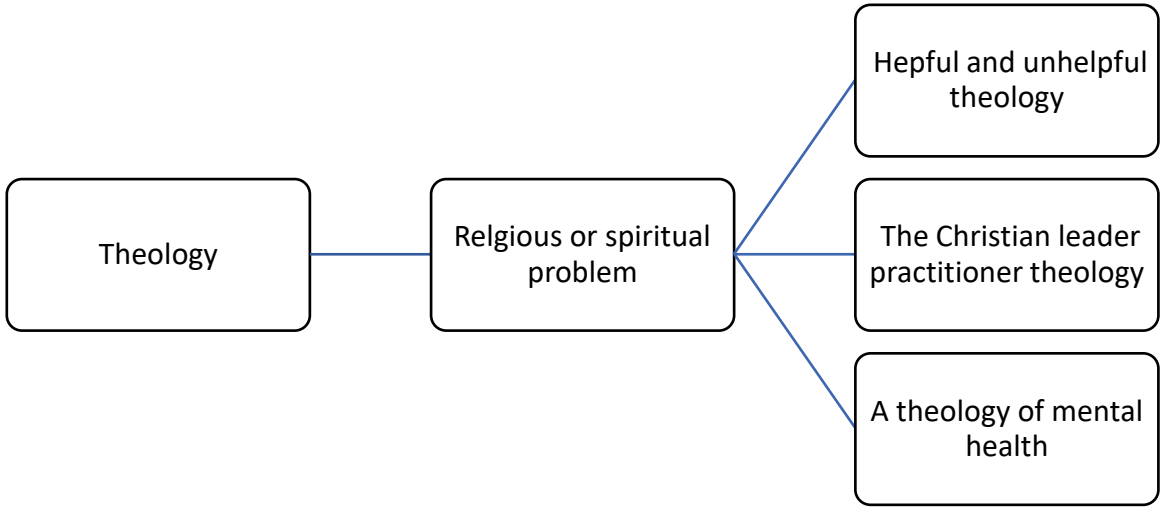
Better equipped:	Mental health Issues	Training Needs
	1. Lack of support 2. Attitudes and isolations 3. Theological understanding 4. Stigma 5. Awareness of MH Issues 6. Mental health needs assessments 7. The Demonic 8. Clinical versus the Spiritual	1. Understanding mental Health 2. Lack of training in mental health 3. Collaboration with mental health services and professional 4. Referrals to services 5. Referrals and collaborating with MH Agencies 6. Stigma 7. Attitudes 8. Understanding pastoral care: 9. Listening, compassion etc. 10. Mental Health Theology
Church and Mental Health	**Pastoral Care**	**Theology**
	1. What is it? 2. Listening 3. Fears 4. We are priests and not psychiatrists 5. Time-consuming and difficult 6. Attitudes Fears 7. Educating Church members 8. Listening 9. What is it?	1. Theological challenges 2. The demonic and possible abuse 3. How does mental health look like? 4. The Demonic 5. We are pastors, not a psychiatrist

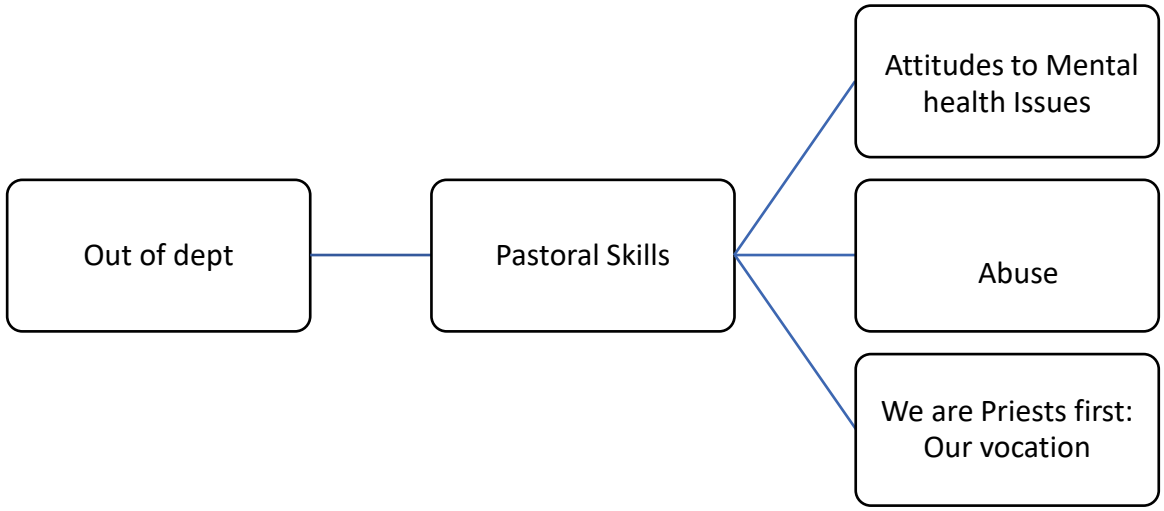

Time consuming
Abuse
Lack of knowledge
Collaborating with MH
Pastoral Skills
A mental health training that equip Christian pastors
Good and effective Practice
Medical versus spiritual
Understanding Mental health
Theology
Challenge Attitudes
Referral /Signposting
Barriers Accessing
Unhelpful theology
Health care practitioner theology

Appendix 16 Themes (sometimes referred to as category)




Mental Health Knowledge and Language
Lack of Knowledge
No Referrals
Less/No Collaborating
Creates Barriers


Theology
Relgious or spiritual problem
Hepful and unhelpful theology
The Christian leader practitioner theology
A theology of mental health


Out of dept
Pastoral Skills
Attitudes to Mental health Issues
Abuse
We are Priests first: Our vocation

Appendix 17 Southeast 1 Feedback

Southeast 1 "Cooperative Inquiry" resume a face-to-face meeting to review the research findings on 27 June 2018, sixteen months after our last meeting.

Participants present: Three Christian leaders; Eli, Angelina, Emilia

Received one apology: Shania

Elia was nominated to write the flip-chart notes

I presented to the group the following papers.

- Paper 1: - SOUTHEAST 1 INITIAL CODING (Appendix 11, p.1-14)
- Paper 2: - SOUTHEAST 1 INITIAL CODING (Appendix 12)
- Paper 3: - SOUTHEAST 1 GENERATING THEMES (Appendices 15 & 16)
- Paper 4: - FINDING (Appendix 19)

I explained Papers 1, 2 and 3.

They asked why the use of Bourdieu. I explained both Thematic analysis and Bourdieu.

Discussing my findings

1. Clergy lack resources and resources provided are not adequate.
2. Feel both stuck and out of their depth working with congregants: Struggling to pastor
3. Prayer seems to fail them.
4. Unhelpful theology of mental health illness: demonic causes, faithlessness,
5. Negative attitudes of mental health

6. Feel they need to Understand the field of mental health, Roles and language
7. Creating partnerships with mental health services and conversant with referral pathways

These findings suggested that

- You, as participants are still struggling to care for your congregants and feeling isolated in mental health care.
- Learning about relevant language to help to communicate and care
- Your responses are not taken seriously or respected.
- Is the faith response legitimate or silenced?

Participant Summary Feedback

A Theology of care that worked in line with the philosophy of the NHS rather than against it is a reasonable point to make; the church is struggling to care for its congregants compare to congregants with no mental health issues

The feedback from both highlighted the confusing and ambiguous questions

There are a lot of ministers that listens whether that comes from compassion or spiritual life, they are doing more than listening, Doctors don't always hear, don't have the time to listen

Whether it is from mild depression to struggling cases, much more complicated cases and helping with practical things

Maybe the health professionals are concerned that pastors will be diving into something they don't understand that is why the care that we do give, I don't it is negative, but it is undenied.

Fear from the professional habitus that pastors don't understand but talk about evils spirit.

When professional are not people of faith, then they won't understand.

The power of professional dismisses faith input.

The church also doesn't have the understanding, and it is than ones with the least experience that makes an effort to learn more.

There is a recognition in the church that we don't understand mental health or parts of mental health,

Collaboration comes in.

Churches are not being engaged, the spirituality of people using services needs to be taken seriously,

Day by day – the work of church leaders help patients cope emotionally. The ministers' hugs enabled me to cope emotionally. Christian leaders do a lot that needs recognition, a lot of it is about accompanying

The willingness to engage

To certain extents, the ministers have the time to engage with congregants that the mental health professional doesn't have

Break: -

That willingness to engage for several ministers is valid, but they also get - but you do worry about getting out of your depth, that why I think there should be more understanding/time and more working together.

For the church pastor, a lot more get missed if there was not a better understanding

There is more respect for chaplains, asked whether that was the case

If they are not going to talk with the chaplains, then they are not going to engage with the broader church, are they?

Learning the language could public

Churches don't know what spirituality means, and some pastors are threatened by it, it borders on new ageism

Care for people with mental health is part of our ministry, being with people of our community Final **comment.**
Do you agree with the findings or disagree, and are there any interesting comments?

A very well thought out analysis

The pluses and barriers are very helpful; it uncovers some essential issues

The silencing of faith is necessary to me

A wider wake up call to the church

Collaboration is critical for any meaningful work

The is preventative, the church is doing well, and people are embracing her, and it is just wonderful to see it.

Engagement with reality and theological shift

Any interesting comments:

Encouraging research, and the right timing for this work, it produces some

Appendix 18 Southeast 2 Feedback

Southeast 2 "Cooperative Inquiry" resume a face-to-face meeting to review the research findings on 25 June 2018, seventeen months after our last meeting.

Participants present: Seven Christian leaders Received two apologies, and one joined via a conference call.
Jo was nominated to write the flip-chart notes

I presented to the group the following papers.

- Paper 1: - SOUTHEAST 2 INITIAL CODING (Appendix 11, p.15-24)
- Paper 2: - SOUTHEAST 2 INITIAL CODING (Appendix 13)
- Paper 3: - SOUTHEAST 2 GENERATING THEMES (Appendices 15 & 16)
- Paper 4: - FINDING (Appendix 19)

I explained Papers 1, 2 and 3.

They asked why the use of Bourdieu. I explained both Thematic analysis and Bourdieu.

Discussing my findings

1. Clergy lack resources and resources provided are not adequate.
2. Feel both stuck and out of their depth working with congregants: Struggling to pastor
3. Prayer seems to fail them.
4. Unhelpful theology of mental health illness: demonic causes, faithlessness,

5. Negative attitudes of mental health
6. Feel they need to Understand the field of mental health, Roles and language
7. Creating partnerships with mental health services and conversant with referral pathways

These findings suggested that

- You, as participants are still struggling to care for your congregants and feeling isolated in mental health care.
- Learning about relevant language to help to communicate and care
- Your responses are not taken seriously or respected.
- Is the faith response legitimate or silenced?

Participant Summary Feedback

June, I like your findings; they express and captures our discussion.

All Christian leaders wanted to know the difference between unhelpful theology and health care practitioner theology. Kay asked what I meant by the health care practitioner theology? What theology informs our care in mental health.

Jo explained that during our inquiry, the whole group didn't dispute the demonic. But the question was about whether demon possession helped describe congregant mental health? It is not about demonic possession, but how to get people Okay again to function and not to exacerbate their condition with the demonic causation, because it causes anxiety for some congregant.

Jo asked; if the health care practitioner believes in demonic possession, can they practise health care? Can they care for someone with mental health issues? If you the pastor say a congregant has got demonic possession, what does that mean for me as a person (congregant)? Does it stigmatise or help me (congregant)? Does it worsen my sense of illness? Does it make people

helpless or a pushover, or does it help? Exorcism and deliverance is a taboo in the NHS but not in the churches.

Unhelpful theology causes anxiety, demon possession; identified as unhelpful to categorise mental health issues that the Christian leaders struggle with the problems of demons. This theme captures theology that ate helpful to congregants and the mental health field.

It's 7 o'clock, and we hope to finish by 8 pm, Jo shall I carry on or stop for a short break. We reconvene at 7.10: please audio recording is back on:

Our role is unique. Therefore, we have to be open as a minister who isn't threatened by mental health issues and be able to work and support congregants. We are not mental health practitioners or a nurse or a psychiatrist or the NHS. It is not about them and us, but to be or work in partnership. However, there are questions about our practice from mental health workers how we support people. Protect our territories. (Venette)

We can help you, therefore, signposting, for me (Venette) learning the language is very important. Jacob felt the church hadn't lost its voice, and chaplaincy could bridge the gap for the church to regain its voice. The mental health professional may find it difficult to form a partnership with our church, says Jacob.

General comments:

Josiah, where is God in your work? Jacob asked. It was essential to include the role of God in mental health.

We have to learn the language of mental health and religion and spirituality of our faith dispositions. Congregant wellbeing is the recognition of both medicine and spirituality.

Professionals are suspicious about us pastors, so we need the balance.

God, prayer and healing:

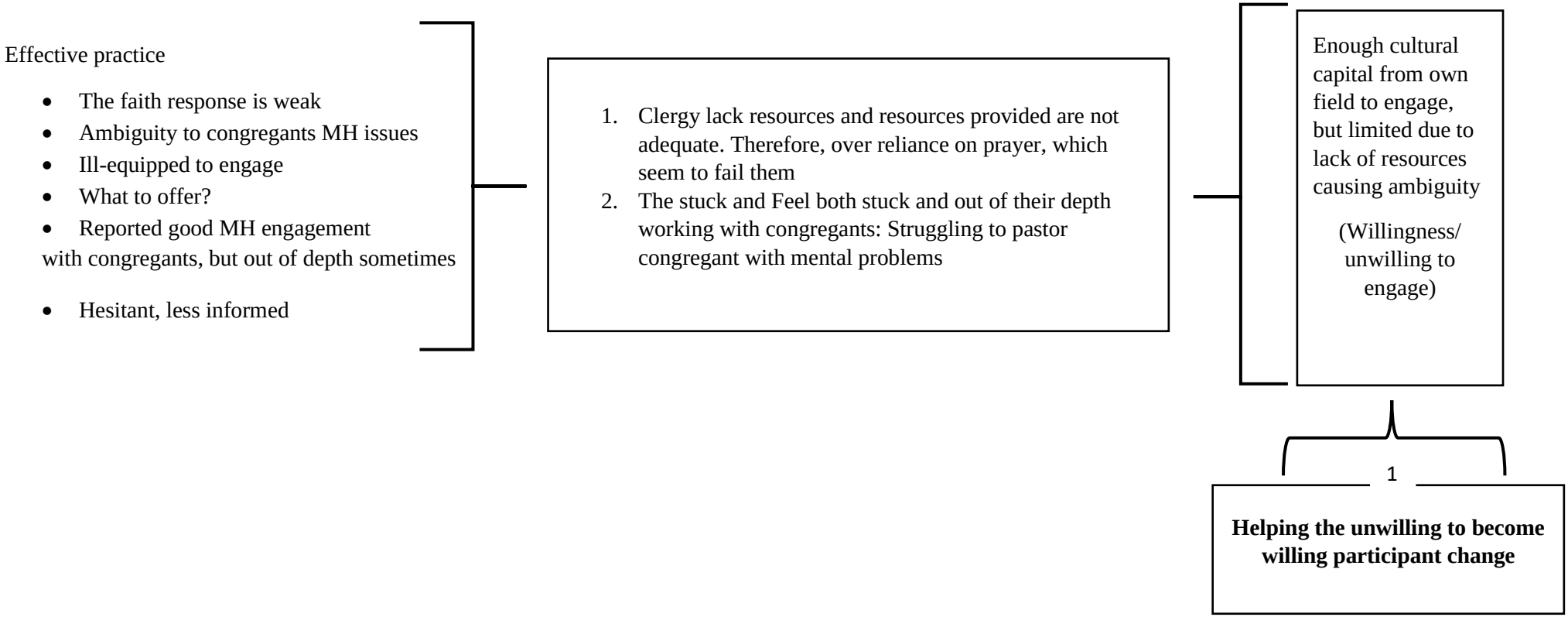
We are not respected! It is timely research and supports your findings

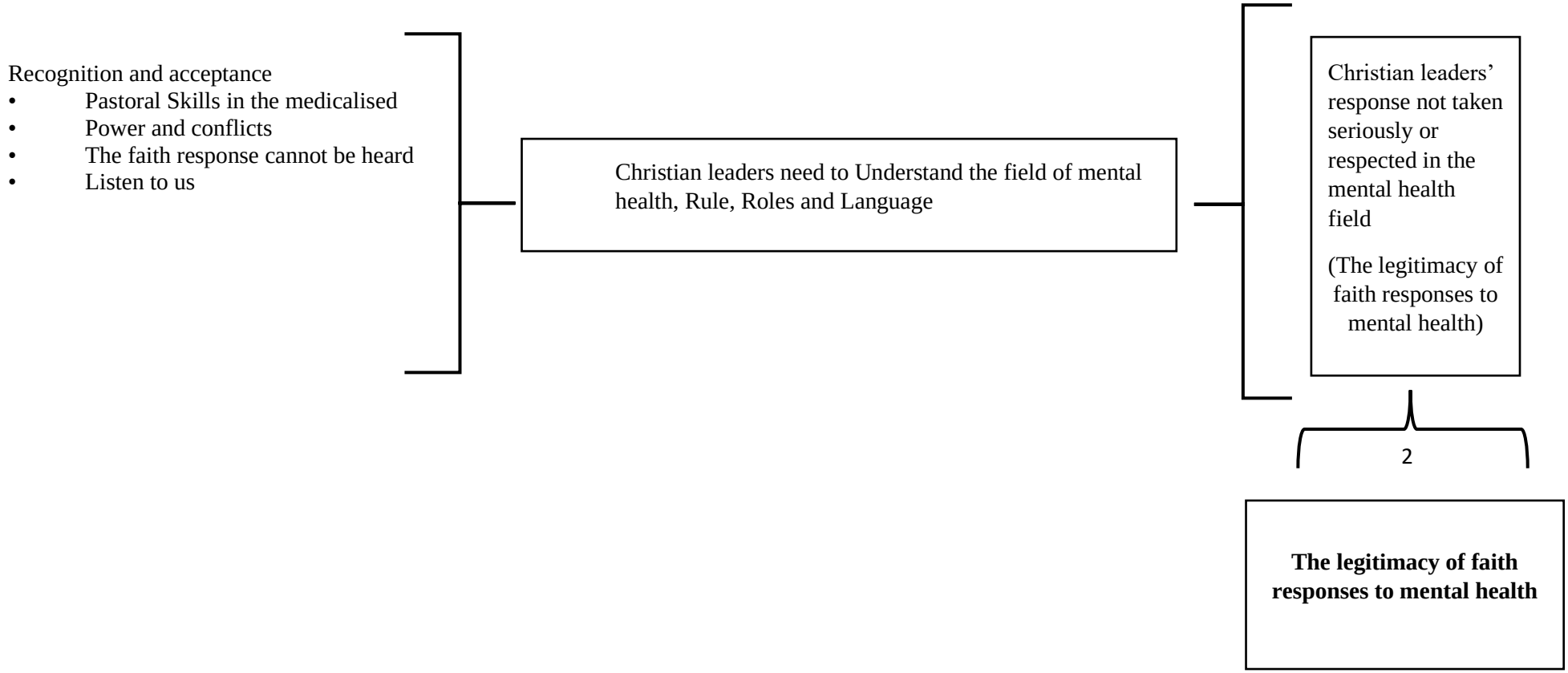
The church has the capital and in my church; we are using it very well but lacking in other areas.

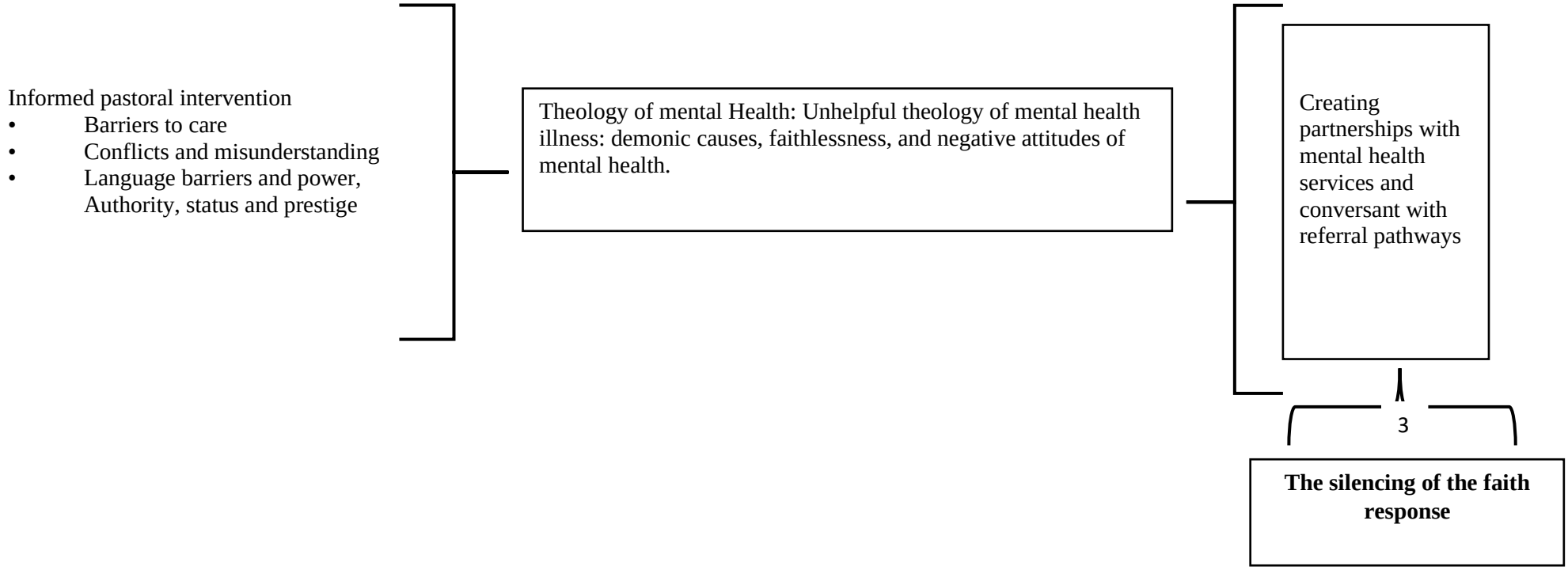
Thanks for coming, we have had a fruitful meeting and thank you for your feedback. Should anyone like to talk to me regarding this again, please email me. Send afterthoughts which I am happy to share.

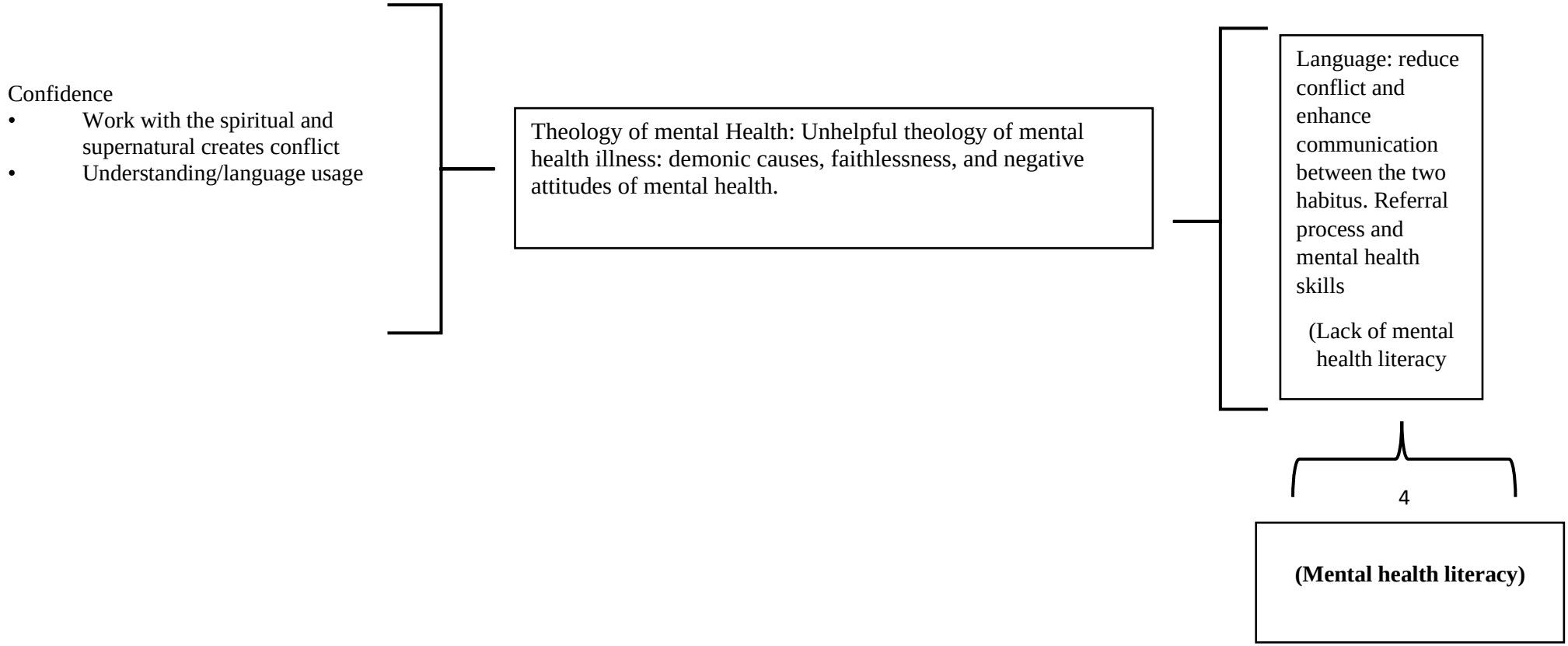
Appendix 19 Latent Finding

(discussion using Bourdieu concept of Habitus Cultural Capital and Field)




Recognition and acceptance
• Pastoral Skills in the medicalised
• Power and conflicts
• The faith response cannot be heard
• Listen to us
Christian leaders need to Understand the field of mental health, Rule, Roles and Language
Christian leaders' response not taken seriously or respected in the mental health field
(The legitimacy of faith responses to mental health)
2
The legitimacy of faith responses to mental health


Informed pastoral intervention
• Barriers to care
• Conflicts and misunderstanding
• Language barriers and power, Authority, status and prestige
Theology of mental Health: Unhelpful theology of mental health illness: demonic causes, faithlessness, and negative attitudes of mental health.
Creating partnerships with mental health services and conversant with referral pathways
3
The silencing of the faith response


Confidence
• Work with the spiritual and supernatural creates conflict
• Understanding/language usage
Theology of mental Health: Unhelpful theology of mental health illness: demonic causes, faithlessness, and negative attitudes of mental health.
Language: reduce conflict and enhance communication between the two habitus. Referral process and mental health skills
(Lack of mental health literacy
4
(Mental health literacy)

Appendix 20 Curriculum

Mental health /mental issues in pastoral care for Christian leaders

Module leader	**Additional tutors:** A psychologist working in mental health Presentation from a variety of mental health professionals, chaplains

The main aim of the module:

To develop Christian leaders' understanding of mental health and mental anguish and collaborate with professionals in the mental health fields to support congregants.

Main Topics of Study

1. Spiritual approaches to the field of mental health, including general understandings and those specific to faith groups:
    - Mental health issues and demon possession:
    - Discussion on cases from medieval literature, a critical discussion
    - Demon possession (views from medical professionals)
    - Demon possession and deliverance prayers (Case study; discussion from psychology, chaplain and psychiatry)
    -
2. Clinical/ medical models of mental health and mental anguish, and how these impact practice in healthcare
    - The origins of mental health, what is mental illness and treatments. (Delivered by a psychiatrist, psychologist)

- Basic clinical assessment, the processes involved in a clinical assessment
- Religious Ideations in mental health
-

3. Communication – Explore different listening modules
    - Pastoral Skills
    - External Unifying centre model
    - Practicum on developing listening skills
    -
4. Theological and pastoral reflection
    - Case study presentations on mental health issues and anguish.
    - Ways of working, the clinical model, religious understandings and theological reflection model
5. Conversation with professional from the mental health field on
    - Partnership / collaboration
    - Referrals
    - Models of recovery
6. Fieldwork: Participants would be required to undertake a mental health project in their local churches and share them with congregants.
    - Discussing congregants' feedback with course participants
7. Is there a theology of mental illness
    -

Learning Outcomes

At the end of this module, Christian leaders will be able:

- To demonstrate high knowledge and understanding of mental health within a spiritual, religious and clinical/medical context.
- To demonstrate an understanding of vital clinical models of mental health issues and mental distress. Including biological, psychological, social approaches.

- To reflect on different approaches, and how these impacts both the Christian leader and congregant.
- To demonstrate an understanding of common mental health issues and associated presentations.
- To understand and familiarise with key psychiatric terminology to enhance effective communication with statutory services in the NHS
- To demonstrate an understanding and awareness of how mental health services operate.
- To demonstrate an understanding of the role of psychology and psychiatry in the treating of mental distress.
- To integrate theology within psychiatry fields, developing a theological response to the mental health context.
- Develop a theological understanding of mental health problems for Christian leaders in the mental health context: the biblical and historical context/ the mental health context and their significance for the local church and congregant with mental health issues.
- To demonstrate an ability to respond appropriately to scenarios in which risk to an individual may be present.
- To be able to suggest a referral pathway to congregants and able to collaborate with services
- To be able to communicate effectively about mental health issues with congregants.

Teaching/Learning Methods

Learning will be facilitated via multiple formats, including didactic teaching, role-plays and demonstrations, group discussions, individual reading, and pastoral/theological reflections.

Assessment Profile
Attendance record (minimum 80% attendance required to pass)

Observation by the course tutor- A pastoral reflective journal discussion Reflections on suggested reading materials
Teaching and Learning Time: Student-Tutor Contact Time: Student Learning Time: Reading, Assignment Preparation and Journal and mental health field project.
Pastoral and Theological Reflective Practice relating to the central studies in section 4, 5 and 7 above

Module leader:	**Additional tutors:**

The main aim of the module:

Christian leaders reflect on their own backgrounds, assumptions, beliefs, and biases to allow them to consider what they bring to their current role and the unique opportunities and challenges this role affords.

Main topics of study:

Some dissemination of information around methods and opportunities for reflection; however, most contents studied and discussed will arise as presented by participants during the programme.

Learning Outcomes:

At the end of this model, participants could

1. demonstrate advanced knowledge of the complex contemporary mental health issues relating to the practice of pastoral care
2. apply critical pastoral skills and insights of biblical and theological scholarship to the practice of mental health care.
3. Demonstrate an awareness of your own beliefs and how your own lived experience has contributed to these.

4. To demonstrate an ability to work with own theology, feelings, and reactions when responding to a person in distress.
5. To demonstrate an appreciation of the impact of theological assumptions as they arise in daily pastoral practices.
6. To demonstrate a willingness to actively consider and explore your ideas and assumptions within a contained reflective space.

Teaching/Learning Methods

Learning would be facilitated by a series of conversations around different theological themes, e.g., discussion, reflection on the process, and demonstration.

Assessment Profile
1. Personal journal 500 words plus group discussion 2. Theological and pastoral reflection 500 to 1000 words plus group discussions 3. Observation by the course tutor 4. Reading of appropriate texts will be recommended.
Teaching and Learning Time: to be considered Including student /tutor contact time: Student Learning Time Reflective group: Reading, recording and reflection:

Reflective practice sessions

Module leader:	**Additional tutors:**

	All

The main aim of the module:

To show that the student can integrate insights and content from teaching seminars and reflective sessions into practice.

Main topics of study:

The actual integration of spirituality and mental health within the context of each participant's faith community and its theology

Learning Outcomes:

At the end of this model, participants could

- Demonstrate how concepts and approaches within clinical and spiritual contexts are integrated within the Christian leader's community.
- To demonstrate a thoughtful response to needs arising from theologically using the public theology model.
- To demonstrate thoughtful consideration of ways to both proactively and reactively support congregants' relation to their mental wellbeing.

Teaching/Learning Methods:

Discussion on different themes. Participants will be required to plan and complete a project and submit a written piece documenting details of their project and reflections on this process and their learning.

Assessment Profile
Observation by a course tutor
Written assignment (project summary and reflections)

Journal’ Reading recommended texts and books.
Teaching and Learning Time: Including student /tutor contact time: Student Learning Time Contact time during practicum sessions: Project work: Reading, reflection, and documentation:

TEACHING AND LEARNING METHODS

Teaching Sessions/ Seminars

Delivery of content will primarily be facilitated via didactic teaching sessions in the first instance, with the expectation that this will naturally be followed with a discussion within the group to explore different themes, ideas, and challenges arising from the material.

These sessions aim to come away with a clearer understanding of what is meant by ‘mental health’ and ‘mental distress’ for congregants in the contexts of healthcare.

This will necessarily include some direct teaching around matters such as diagnostic terminology and other models for understanding mental health; however, participants aim to form and challenge their theological positions around these topics, rather than merely receiving information.

Practicum

It is expected that Christian leaders will take away classroom-based learning from the course and put new ideas into practice within existing work environments. This may include working with other Christian leaders to

establish new ways of supporting congregants presenting with mental distress, or considering how this is already undertaken

Christian leaders may be encouraged to consider journal practice and bring ideas and reflections to reflective practice groups.

Theological practice rationale.

A central aspect of this training programme's ethos is that participants must be free to develop a theological understanding of mental health issues. This will be supported by the delivery of evidence-based theory from both healthcare and theological perspectives, which they may then integrate and juxtapose alongside their own belief system. Doing this is necessarily challenging and will require a space where participants have an opportunity to grapple with these ideas alongside one another.

Consideration of mental health and mental health difficulties is likely to resonate in different ways with individual participants. It will be necessary for a 'safe space' to be provided in which these reactions, and their impact on professional practice, can be explored and supported.

Reflective practice by course facilitators

Reflective practice is, of course, essential for those running the programme. Facilitators will debrief following each session and plan additional regular meetings to reflect on the course content and delivery. An action-research evaluation will take place alongside the course's delivery, which will further promote this process.