

## The devil is in the detail: partnerships between psychiatry and faith-based organisations

GERARD LEAVEY and MICHAEL KING

**Summary** Clergy continue to have a central role in many communities and the utility of their involvement in the care of people with mental health problems is increasingly argued. However, there has been a failure to examine the form and parameters of partnerships between faith-based organisations and psychiatry.

**Declaration of interest** None.

The view that we live in an increasingly secular world is widely held in Western societies. However, the nature of secularism remains complex and disputed, divided by public–private perspectives. Thus, for some it is the decline of religion in institutional and public life, whereas for others it is the dwindling of spiritual and religious consciousness among individuals. For the secularist, the trend towards religious disaffiliation in Western societies is desirable and inexorable. Critics of this position point to an increasingly private, *à la carte* spirituality, often divorced from regular religious observance (Roof, 2001). The secular debate notwithstanding, we live in an increasingly plural society where religion is an integral and immutable part of identity for many people, governing aspects of their beliefs and behaviour. Religion and religious identity in many Western countries has ceased to be a marginal concern and has moved centre stage, generating not just political debate but new policy and legislation. In the UK this has been borne out by the inclusion of a religious affiliation question in the 2001 census. The issues of religious freedom and equality have been established within the Human Rights Act and the European Convention on Human Rights.

The past decade has seen a growing demand for health professionals to take better account of patients' religious beliefs and

establish links with faith-based organisations as partners in health and welfare services (Mental Health Foundation, 1997; National Institute for Mental Health in England, 2003). The rationale for this partnership is based on faith communities' declared commitment to entwined spiritual and social values, and their deep-rooted social connections (Home Office Faith Communities Unit, 2004). These emerge in the health literature as the potential public health value attached to notions of social capital (McKenzie *et al*, 2002).

Religion-based communities are considered to be exemplars of social capital ideals of reciprocity, integration, socialisation, activism and voluntarism, which are thought to solidify the community and benefit the individual. This counter-anomic vision of religion suggests that the incorporation of faith-based organisations as adjuncts to statutory sector health and welfare is a sensible move. However, although psychiatry and religion share similar concerns, their relationship has seldom been harmonious, with perhaps just cause for suspicion on both sides (Bhugra, 1997). In this editorial we outline some of the key issues in clergy–psychiatry partnerships, pointing to the reasons why building partnerships with faith groups and clergy is useful and necessary. However, although there is a need for dialogue and mutual understanding, there is also a need for psychiatry to examine the nature and boundaries of proposed relationships.

### EXPLANATORY MODELS, CLERGY AND HELP-SEEKING

In the USA, analysis of the National Comorbidity Survey conducted in the 1990s revealed continuing use of the clergy alone and alongside professional and alternative practitioners for mental health problems. However, given that many self-help groups and recovery movements are faith-based,

the study might have underestimated the role of religion in the delivery of services to patients with mental illness (Wang *et al*, 2003). Nevertheless, it is clear that faith-based organisations and their clergy are contacted by people with mental health problems, often in preference to consulting psychiatric professionals. This preference is influenced by somewhat intersecting cultural and service-related factors. These can be characterised in positive and negative terms.

Broadly speaking, healing has been observed as a central function of most religions and some people look to religion as a means of understanding suffering and as a beneficial way of coping with it. However, from a more negative standpoint, some of the reluctance of congregation members to consult psychiatry, psychotherapy or counselling services may be explained by a posited 'religiosity gap' between the religious patient and mental health professionals. There is some evidence, often anecdotal, that psychiatrists are viewed suspiciously by religious adherents (Mitchell & Baker, 2000). Consequently, as a form of self-protection such patients may conceal their religious beliefs, fearful that they will be regarded as further indications of mental pathology (Leavey, 2004). Additionally, ethno-cultural beliefs of patients and their families determine help-seeking. Studies in the UK indicate that culturally mediated religious beliefs influence differential access to, and engagement and satisfaction with, services (McCabe & Priebe, 2004).

Members of many minority ethnic communities are more exposed to risk factors for mental health problems (unemployment, poor housing and discrimination) than their majority White counterparts. Moreover, it is important to bear in mind that in many minority ethnic communities, particularly the recently arrived, clergy have a pivotal role as gatekeepers for services, advisors and mediators between government and communities. The clergy are popularly conceived of as knowledgeable and trusted brokers at local and personal levels. With respect to mental illness, clergy in closed, less secularised communities may play a pivotal part when people first present with psychological difficulties, thereby strengthening or challenging religious health beliefs and, in effect, advocating spiritual or secular intervention (Littlewood & Dein, 1995). Among religious adherents there may be a demand

for clergy to be absolutist and directive, particularly when depression and anxiety are framed as moral disorders.

## PROBLEMS OF PARTNERSHIPS

Generally, when clergy–psychiatry partnerships are proposed there are a number of underlying assumptions. Dominant among these is that dialogue and mutual understanding will assuage the suspicions and estrangement between the two sectors. It is also often assumed that all clergy share a biomedical conceptualisation of illness and are willing to offer time and resources in the care of psychiatric patients. However, we need to be clear what is meant by the notion of partnership. As we discuss, these assumptions ignore difficult issues on both sides.

First, although many clergy already provide pastoral care for emotionally distressed people, they may be reluctant to move further away from spiritual guidance – their ‘core business’ – towards a more secular enterprise. Second, there are considerable difficulties for psychiatry in the disjunction between biomedical and spiritual concepts of severe mental illness, their origins and their resolution. When religious individuals and their clergy have coincident beliefs about the supernatural origins of illness it seems likely that this will have serious implications for pathways to appropriate care and compliance with treatment. Although it is important to stress the heterogeneity of beliefs about suffering and healing found among mainstream organisations, this concern has particular resonance in relation to certain evangelical and Pentecostal churches which maintain deeply held beliefs and practices surrounding demonic possession, healing and deliverance rituals. Recent high-profile cases in the UK, such as that of Victoria Climbié (Laming, 2003), point to the strength of such beliefs among African Pentecostal churches and the potential for tragedy. How should mental health professionals engage with clergy who believe that sin or demonic possession lies at the root of a person’s illness? It seems unlikely for clinical and legal reasons that services could or should collude with religious healing

GERARD LEAVEY, PhD, Barnet, Enfield and Haringey Mental Health NHS Trust and Department of Mental Health Sciences, University College London; MICHAEL KING, PhD, Department of Mental Health Sciences, University College London, London, UK

Correspondence: Dr Gerard Leavey, Research & Development Department, St Ann’s Hospital, St Ann’s Road, London N15 3TH, UK. Email: gerard.leavey@beh-mht.nhs.uk

(First received 14 December 2006, final revision 28 February 2007, accepted 8 March 2007)

rituals. Similarly, contested normative values, such as those related to sexuality, are not easily reconciled and may require clinicians to question and challenge fundamental tenets of certain faith groups. If this is the case, aside from any consideration of resources for training and personnel, the psychiatric role may become a persuasive and didactic one rather than a process of mutual enlightenment.

Third, our globalised post-modern world is characterised by diversity and pluralism. This is also true of belief systems and faith groups. Although it is likely that the larger, more established faith groups are more easily approached, how inclusive should be the dialogue and collaboration? How should we evaluate the representativeness of minority religious or faith groups? Should health providers reach out to groups that might be considered too ‘fringe’ – the independent Pentecostal churches, the Moonies or the International Society for Krishna Consciousness, for example? To ignore them might leave health providers vulnerable to accusations of discrimination and the possibility of litigation. Moreover, paradoxically, it may be among the smaller, more esoteric and less visible groups that dialogue with mental health services is most profitable.

## CONCLUSIONS

Faith-based organisations across the religious spectrum have a pivotal role in the lives of many people, particularly those of Black and minority ethnic communities. As Western governments are beginning to realise, there is no doubt that the skills and capacity of faith communities are underused by health and welfare providers. However, the potential contribution of

such organisations and how it would fit with existing statutory provision have yet to be fully examined. The purpose of this editorial is not to decry the need for dialogue and collaboration with clergy, but rather to begin a realistic appraisal of the difficulties, both clinical and legal, and the resources required for such partnerships.

## REFERENCES

- Bhugra, D. (1997)** *Psychiatry and Religion: Context, Consensus and Controversies*. Routledge.
- Home Office Faith Communities Unit (2004)** *Working Together: Co-Operation Between Government and Faith Communities*. UK Home Office.
- Laming, H. (2003)** *The Victoria Climbié Inquiry*. TSO (The Stationery Office).
- Leavey, G. (2004)** Identity and belief within black Pentecostalism. In *Identity and Health* (eds D. Kelleher & G. Leavey), pp. 37–58. Routledge.
- Littlewood, R. & Dein, S. (1995)** The effectiveness of words: religion and healing among the Lubavitch of Stamford Hill. *Culture, Medicine and Psychiatry*, **19**, 339–383.
- McCabe, R. & Priebe, S. (2004)** Explanatory models of illness in schizophrenia: comparison of four ethnic groups. *British Journal of Psychiatry*, **185**, 25–30.
- McKenzie, K., Whitley, R. & Weich, S. (2002)** Social capital and mental health. *British Journal of Psychiatry*, **181**, 280–283.
- Mental Health Foundation (1997)** *Knowing Our Own Minds*. Mental Health Foundation.
- Mitchell, J. R. & Baker, M. C. (2000)** Religious commitment and the construal of sources of help for emotional problems. *British Journal of Medical Psychology*, **73**, 289–301.
- National Institute for Mental Health in England (2003)** *Inspiring Hope: Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health*. NIMHE.
- Roof, W. C. (2001)** *The Spiritual Marketplace: Baby-Boomers and the Remaking of American Religion*. Princeton University Press.
- Wang, P. S., Berglund, P. A. & Kessler, R. C. (2003)** Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, **38**, 647–673.