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The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

A thesis submitted in partial fulfilment of the requirements for the Doctorate in Clinical Psychology

University of Sheffield

2011

Sarah Wonders

Declaration

This work has not been submitted to any other institution, or for the purpose of obtaining any other qualification.

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Abstract

This thesis comprises a literature review and a research report. The review provides a critical evaluation and summary of the qualitative literature pertaining to religious and spiritual issues in psychotherapy and counselling. Therapist and client perspectives are included. The findings are summarised thematically and the implications for research and practice are outlined.

The research study utilised Interpretative Phenomenological Analysis to explore the experiences of eight Christian clergy in providing pastoral care to support people with their mental health. It also explored their experiences interacting with statutory services in order to do this. Data were gathered using semi-structured interviews. Both lay and ordained clergy representing a variety of Christian denominations were included in the sample. The results are considered in relation to previous research and implications for research and practice outlined.

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Section 1

Literature review

Religion and spirituality in psychotherapy and counselling: A review of clients' and clinicians' experiences.

Abstract

This review offers a critical evaluation and summary of the existing empirical literature relating to the experience of religion and spirituality (RS) within psychotherapy and counselling. Only qualitative studies conducted with clients and/or therapists were included. The studies were critically evaluated and clustered into the following thematic areas: (1) Guiding principles: Ethical practice and following the clients' lead; (2) Self in therapy; (3) Emergence of RS issues in therapy: Proceed with caution; (4) Assessing healthy and unhealthy beliefs; (5) Blurring the spiritual and the secular; (6) RS as adding something extra; (7) Discomfort and distancing from religion and; (8) Institutional/contextual barriers. All studies utilised interview data, however a range of qualitative methodologies were applied. The quality of the studies varied, however several rigorous studies were included. The findings are discussed in relation to the implications for future research and clinical practice.

Keywords: Religion, spirituality, psychotherapy, counselling, review, qualitative.

Introduction

Over recent years clients of mental health services have consistently voiced that their religious and/or spiritual (RS) beliefs are relevant and important aspects of their care (Koslander & Arvidsson, 2006; Mental Health Foundation [MHF] 2002, 2007). Purely scientific explanations, which prevail in healthcare settings, may be viewed by some service-users as insufficient (Department of Health [DoH] 2009, p.11). The UK Department of Health has published guidelines which recognise the need to consider spirituality as part of the provision of holistic care, and highlighted that supernatural understandings of health and illness may need to be taken into account due to their influence on peoples' attitudes, which may impact upon treatment choices and outcomes (DoH, 2009).

A distinction can be made between spirituality and religion. Spirituality is a broader concept encompassing the search for meaning, and connection with the self, the environment and others, as well as transcendent aspects of being (MHF, 2007). Religion is a narrower term relating to particular sets of beliefs or values, usually shared by a group of persons, following the teachings of a divine leader or deity (Koenig, 2009). Whilst the distinction between religion and spirituality has been outlined, in order to enhance readability the abbreviation 'RS' will be used throughout this review to encompass both religion and spirituality (whilst recognising that not all of those who are spiritual are religious).

In inpatient settings, service-users' spiritual needs may be addressed by doctors, other health professionals or hospital chaplains. Yet the majority of mental health service-users in the UK access therapeutic support in the community as outpatients in primary,

secondary or tertiary care. Individuals may also seek psychotherapy or counselling from private or voluntary agencies. Rose, Westefeld and Ansley (2001) found that 55% of clients sampled stated that they wanted to discuss RS issues in therapy, yet there is a suggestion within the literature that this does not happen frequently (Awara & Fasey, 2008). This may be accounted for by a variety of factors including the established finding that there is a discrepancy between the prevalence of RS beliefs in health professionals (who are less likely to hold RS beliefs) and the general population (El-Nimr, Green & Salib, 2004; Shafranske & Maloney, 1990). Whilst many clinicians acknowledge RS as being relevant to client care, this may not be reflected in their practice (Dura-Vila, Hagger, Dean and Leavey, 2011; Foskett, Marriott & Wilson-Rudd, 2004; Shafrankse & Maloney, 1990). Some health professionals may not consider RS as within the domain of healthcare (Foskett, Marriott and Wilson-Rudd, 2004) or may even view such beliefs as detrimental to wellbeing, despite contemporary evidence to the contrary (Koenig, 2009; Cornah, 2006; Moreira-Almeida, Neto & Koenig, 2006). Lack of training or knowledge in RS and personal discomfort may also play a role (Crossley & Salter, 2005).

RS and Mental Health

There has been specific research into the role of RS in different psychological conditions such as psychosis, anxiety, depression, substance-abuse and suicide (Koenig, 2009; MHF, 2007; Moreira-Almeida et al., 2006). The evidence suggests that spirituality generally impacts positively on health and wellbeing although it is recognised that in some cases it can have a negative influence (Moreira-Almeida et al., 2006; Worthington, Kurusu, McCullough & Sandage, 1996). Allport and Ross (1967, cited in Rosenfeld, 2011) made a distinction between intrinsic and extrinsic religious

orientation. Positive mental health outcomes have consistently been associated with intrinsic orientation; where beliefs are internalised and regarded as a guiding force or motivation in life. Benefits may include increased resilience, social support through participation in religious communities and connection with God or the transcendent through practices such as prayer, meditation or worship. By contrast, extrinsic religiosity, which views religion as a means of serving other interests (such as distraction or achieving status) has been more commonly associated with negative mental health outcomes (Bergin, 1991; Moreira-Almeida et al., 2006). These may include problems of rigidity and over-control and instances where religion serves to enhance guilt and neuroticism (Rosenfeld, 2011). Thus, the importance is not whether people hold RS beliefs but the qualitative nature of these, that is, *how* people are religious or spiritual. This highlights the utility of qualitative methods in order to advance our understanding in the RS domain.

RS and Therapy

Worthington et al. (1996) published a comprehensive 10-year review of religion and therapeutic process and outcomes, which aimed to analyse and summarise the evidence to guide clinical practice and future research. They evaluated literature relating to religion and clients, religion and therapists and religious counselling techniques. They included studies with lay therapists and clergy as well as professional therapists. Although articles related to 'spirituality' were excluded, the review was arguably too extensive in scope to provide a clear summary for the reader. It was not clear how the studies were evaluated for quality, although some critique of the literature overall was evident. It was also unclear where many of the studies had been conducted, although the discussion suggested the literature was predominantly focussed upon the USA.

Nevertheless, the authors provided some key recommendations for future research. As the reviewed literature mostly focused on *potential* clients they emphasised that research with actual clients and their experiences of religion during therapy should be prioritised in the future. There was also a predominance of quantitative studies within the review. The authors recommended a move "beyond questionnaire studies" (p. 480) demanding greater sophistication and rigour in research methods, and also highlighting a place for qualitative designs.

Following Worthington et al., Post and Wade (2009) reviewed the research into RS in psychotherapy published between 1997 and 2007. This aimed to provide a "concise synthesis" (p.132) of the empirical research and its clinical implications, including both qualitative and quantitative data. The review focussed on three main areas: RS and clients, RS and therapists and RS interventions. However, the quality of this review was poor due to numerous methodological flaws. Whilst acknowledging that the review was not intended to be comprehensive, there was a lack of transparency beyond this. The literature search appeared to be selective rather than systematic and the inclusion/exclusion criteria were not specified. The authors presented the findings of the selected articles, yet there was no evidence of a critical appraisal of these and the results of each study were described rather than synthesised. Whilst implications for clinical practice were outlined, the limitations of the review were not acknowledged and therefore the recommendations possibly extended beyond the scope of the data.

Aim

The current review aims to provide a systematic evaluation and summary of the peer-reviewed qualitative literature relating to clients' and therapists' experiences of religious

and spiritual issues within psychotherapy. Following from Worthington et al.'s review, literature from 1996 onwards was sought. The review focuses upon RS within the process of the therapeutic encounter and hence, unlike Post and Wade (2009) does not review specifically RS adapted therapies, which have been reviewed elsewhere (see Coehlo, Canter & Ernst, 2007; Hodge, 2006; Smith, Bartz & Richards, 2007; Worthington, Hook, Davis & McDaniel, 2010).

Method

Consistent with the aim, the review was limited to empirical qualitative studies in order to summarise in-depth data from clients' and therapists' accounts. Figure 1 (page 10) shows a summary of the search process that was conducted during April and May 2011. Studies were selected according to the following criteria:

Inclusion criteria

- Sample includes clients/patients or therapists (of any mental health profession, practicing psychotherapy or counselling).
- Data focussed upon religion/spirituality within psychotherapy.
- 'Large Q' qualitative studies that collected substantive data using a clearly described exploratory method (see Kidder & Fine, 1987).
- Published in the English Language.

Exclusion criteria

- Experience of RS specialist/integrated therapies (e.g. Christian Cognitive Behavioural Therapy, Meditation group therapy).

- Studies relating to interventions for physical health conditions.
- Discussion papers, books, book reviews.

Search terms

A number of data bases were utilised. Initially, the search terms displayed in Table 1 were entered into PsychINFO and then into Medline, ATLA (religion database) and CINAHL (nursing database).

Table 1

Search Terms

Terms for religion/spirituality	**Terms for therapy**
Spirit*	Therap*
Religio*	Counsel*
Faith*	Psychotherap*
Belief*	Psycholo*
	Clinic*

The terms in each column were combined using the Boolean operator 'OR' and both columns were then combined using the Boolean operator 'AND'. The initial search included all terms as keywords, however this returned 43,536 results, therefore a subsequent search was run, limiting all terms to the title. Given the broad, over-inclusive selection of search terms, it was thought that all relevant papers would be captured by a variation of one of these terms in the title. This second search returned 2520 results.

Results were then limited to peer-reviewed journals in the English Language and articles were limited to 'qualitative study'. A combination of free text terms ('qualitative', 'findings' or 'interview*') were also used to screen for qualitative studies as advised by Shaw (2012). This returned 196 results in total. Titles and abstracts (and full text articles as necessary) were screened to select studies according to the inclusion criteria. Shaw notes the difficulties of identifying qualitative research articles, therefore, further searches were conducted using additional databases and references and citations of relevant articles screened in order to check for studies which may have been missed.

The above search was re-run using Medline and ATLA. This returned 234 results (i.e. a further 38 studies in addition to the original search). The same search in the CINAHL database returned 87 results. There was significant overlap with the PSYCHINFO searches but no additional studies were found which met the inclusion criteria.

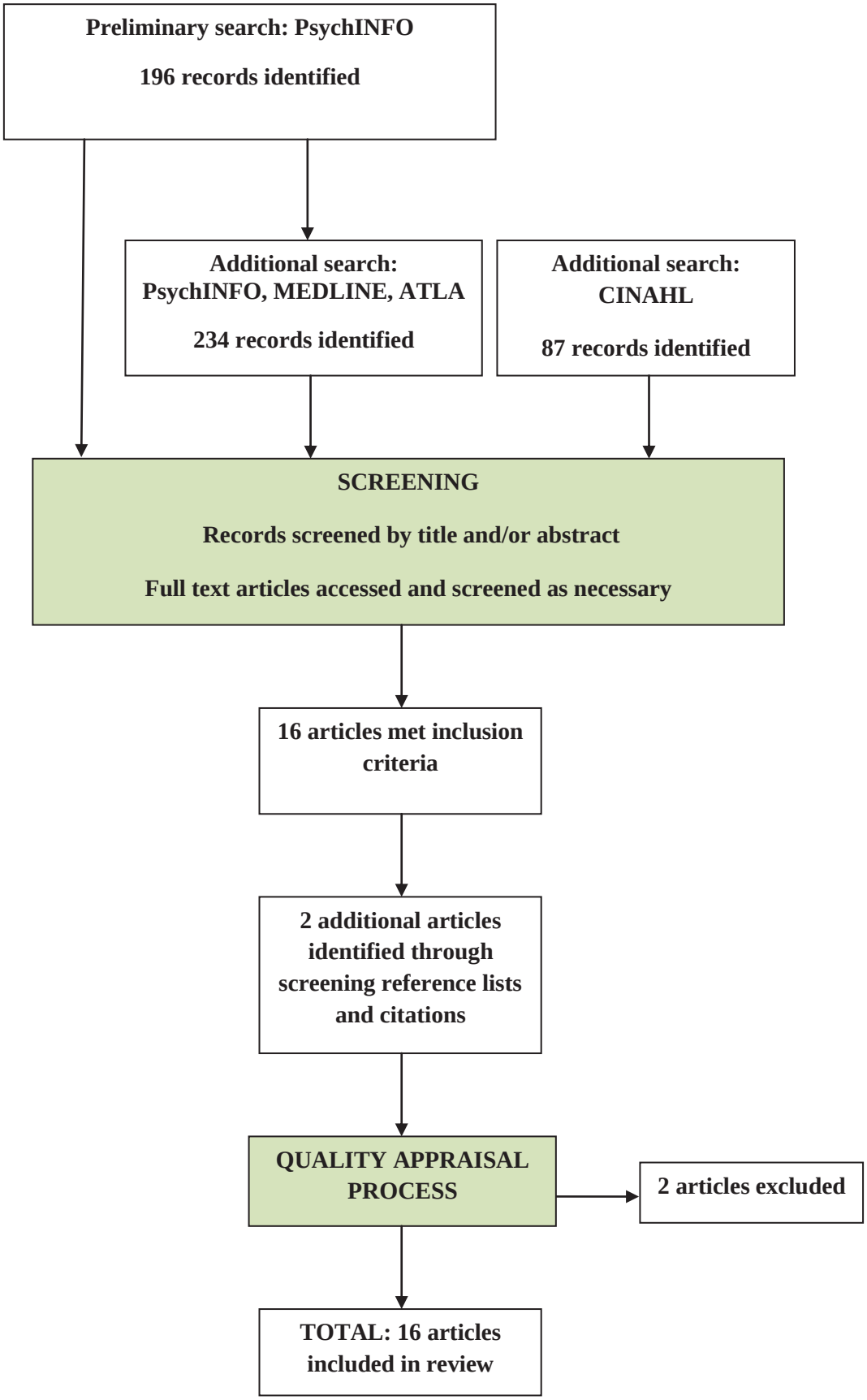

Figure 1. Selection Procedure

Quality control

Papers were read and evaluated for quality. In addition to general principles pertaining to quality in research (clear aims, appropriate method, findings grounded in the data) a variety of guidelines for appraisal of qualitative research also informed the process (Greenhalgh, 2010; Public Health Resource Unit, 2006; Shaw, 2012; Spencer & Ritchie, 2012; Stiles, 1993). In particular, the credibility, dependability and transferability of the findings were appraised by considering whether papers showed evidence of (for example) procedural and interpretative clarity, reflexivity, cross-checking of findings within and between accounts, appropriate sampling, evidence of their findings, adequate contextual information or participant validation.

Two studies were excluded at this stage. Jacobs (2010) had presented selected themes from the data and chosen to exclude the themes which were pertinent to the aims of this review. Ankrah (2002) had utilised a mixed-methods design, however very little qualitative data from the interviews was presented, therefore this was considered insufficiently rigorous for inclusion in this review.

As with primary qualitative researchers, Shaw (2012) argues that those who review qualitative research should also engage in reflexivity. When reviewing the literature the author considered her own stance as a researcher, yet also her position in comparison to the therapist and client participants in the reviewed studies. The author acknowledged where her personal perspective may have interacted with the data, for example, recognising a tendency to notice particular elements of the research which either resonated or conflicted with her own view of spirituality or therapy. This awareness

enabled her to recognise these potential biases and value all perspectives as illuminations of the practice and experience of others.

Findings

A total of 16 studies were identified and included in this review. Fourteen of these were obtained through original searches and two were further identified through citations. The studies are summarised in Table 2. The studies were read and critically appraised and several common themes were identified. The findings will therefore be discussed under the following thematic headings:

- Guiding principles: Ethical practice and following the clients' lead
- Self in therapy
- Emergence of RS issues in therapy: Proceed with caution
- Assessing healthy and unhealthy beliefs
- Blurring the spiritual and the secular
- RS as adding something extra
- Discomfort and distancing from religion
- Institutional/contextual barriers

Table 2.

Summary of Studies.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
Studies from client perspective								
Knox, Catlin, Casper & Schlosser (2005) **USA**	To understand how discussions of RS occur in [secular] therapy and what makes experiences harmful or helpful	12 clients (1 male, 11 female)	n/a	Varied 6 religious/spiritual (not affiliated with any group), 3 Catholic, 3 experienced multiple groups (Buddhism, Hinduism, Judaism, Paganism, Unitarian Universalism)	Not named (Convenience and purposive)	Telephone audio-recorded, semi-structured interviews	Consensual Qualitative Research (CQR)	Participant validation. Cross-checking of analysis. Audit of codes/core ideas. Stability check. Reflexive account.
Mayers, Leavey, Vallianatou & Barker (2007) **UK**	1) Conceptualisation of psychological problems, 2) Influence of beliefs on help-seeking, 3) Experiences of disclosing belief in secular therapy	10 NHS clients (7 female, 3 male; 7 white English, 2 mixed ethnic origin, 1 black Caribbean). Receiving or recently completed therapy. (6 months to 13yrs experience in MH services; depression, PD, eating disorders, bipolar)	n/a	Clients with self-defined strong RS beliefs (Christian, Greek Orthodox and Muslim)	Strategy not described – recruited from NHS setting	Semi-structured interviews (IPA)	IPA	Ongoing audit of analysis and themes. Some reflexivity. Themes evidenced by extracts.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
Gockel (2011) **Canada**	To explore the role of counselling in the narratives of people who draw on spirituality for healing and wellness	12 clients (10 female, 2 male)	n/a	All self-defined as having RS belief. 11 "spiritual not religious" (including 4 who attended religious services), 1 "spiritual and religious" (Zen Buddhism)	Convenience and snowball	Semi-structured interviews	Narrative	Participant validation. Reflexivity mentioned but not evident. Limitations to transferability explicit.
Studies from client and therapist perspective								
Simmonds (2004) **UK & Australia**	Experiences of RS in therapy as patients and as practitioners	25 psychoanalysts/ psychoanalytic psychotherapists	Psychoanalytic	Represented a "variety of spiritual interests"	Not named (Convenience)	Semi-structured interview	Narrative finding and 'coding and editing analysis technique'	(Minimal). Participant validation of transcripts. Constant comparison within/between transcripts.
Martinez & Baker (2000) **UK**	To consider the interplay of personal religiosity and professional experience of psychodynamic therapists	8 psychodynamic counsellors/ therapists	Psychodynamic	All committed Christians	Not named (Convenience)	Semi-structured interview	Grounded Theory	Memo-writing. "Constant comparison" of data. Evidenced by extracts.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
Studies from therapist perspective								
Bell-Tolliver and Wilkerson (2011) **USA**	Explore use of spirituality [and kinship] in therapy with African American clients	30 African-American licensed therapists (21 female, 9 male; 8 marriage & family therapists, 14 social workers, 10 counsellors, 2 psychologists - NB some held dual professional licences)	Not specified	All Christian, various denominations	Snowball	Semi-structured interview	Phenomenological approach	Piloting method. Participant validation of transcripts. Interdisciplinary triangulation - cross-checking of themes.
Baker & Wang (2004) **UK**	How intersection of personal RS belief and workplace may influence practice of participants	14 religiously committed clinical psychologists (11 female, 3 male)	Not specified	All Christian, denominations not specified but recruited from an organisation with greater representation of evangelical Christians	Not named. (Convenience and purposive)	Repertory Grid and semi-structured interview	Grounded Theory	Memo-writing. Constant comparison. Reliability check. Findings evidenced by extracts. Some evidence (minimal) of reflexivity. Findings well supported by extracts.
Wagenfeld-Heintz (2008) **USA**	How psychologists/psychiatrists make sense of their RS beliefs in light of their medical/scientific training and professional/institutional factors which influence this	30 religiously/ spiritually oriented psychologists and psychiatrists (14 female, 16 male)	Unspecified	Judeo-Christian traditions or "non-affilated believers"	Non-random multiple snowball	Interviews	Inductive analysis	Limited. Continual checking of data. Findings supported by extracts.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
McVittie & Tiliopoulos (2007) **UK**	1) How psychotherapists describe practices towards RS clients, 2) How descriptions account for weight given to RS issues in therapy	6 Psychotherapists (3 male, 3 female; 5 clinical psychologists, 1 psychiatrist; 3 NHS, 3 private practice)	Unspecified	1 Christian, 1 atheist, 4 no current religious affiliation (agnostic/atheist)	Purposive	Semi-structured interviews	Discourse analysis	Limited. 2 analysts. Extracts to support findings.
Golsworthy & Coyle (2001) **UK**	"Commonalities and divergence of [bereavement] therapists who frequently encounter religious or spiritual dimensions in their work"	12 bereavement therapists (10 female, 2 male; 4 counsellors, 3 counselling psychologists, 3 social workers and 2 psychotherapists)	Unspecified	7 Christian (3 Roman Catholic, 2 Anglican and 2 non-specified), 3 "spiritual", 1 agnostic, 1 no beliefs	Theoretical	Semi-structured interviews	IPA	Piloting method. Reflexivity evident in relation to RS and therapeutic stance. Interpretations supported by extracts from transcripts.
Jackson and Coyle (2009) **UK**	Explore therapists responses to 'spiritual difference' within therapy, how they represent these (as ethical dilemmas) and construct strategies for responding to these situations	11 practitioners (1 male, 10 female; 3 counselling psychologists, 1 clinical psychologist, 5 psychotherapists, 2 counsellors)	Unspecified	3 Christian, 2 Atheist, 1 Agnostic, 1 Buddhist, 1 Humanist, 1 spiritual, 1 "respectful of others", 1 "none"	Random sample from registered governing bodies. (Method of selection beyond this unclear).	Semi-structured interview including case vignette.	IPA	Very limited. Extracts to evidence findings.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
Wihak & Merali (2005) **Canada**	Non-indigenous counsellors' understanding of indigenous clients' spirituality & how this influences practice	8 female Canadian counsellors (4 social workers, 2 psychologists, 1 pastoral counsellor, 1 criminologist)	Unspecified	2 Jewish, 1 Roman Catholic, 1 Anglican, 1 B'hai, 3 not identified as religious/spiritual	Purposive and convenience	Semi-structured interviews	Analysis of narratives	Participant validation of constructed narratives. Cross-comparison of narratives. Extracts included within narrative.
Crossley & Salter (2005) **UK**	To explore how clinical psychologists address spirituality in therapy	8 NHS clinical psychologists (4male, 4 female)	Eclectic (2), CBT (2), personal-construct (2), systemic (1), community psychology (1)	Varied - included "tentative alignments with religious frameworks, atheist positions and values distinct from transcendent notions"	Convenience and theoretical	Semi-structured interviews	Grounded Theory	Context provided. Good reflexive account. Theoretical sampling. Memo-writing. Adaptation of interview up to saturation of accounts. Peer discussion. Extracts to evidence findings.
Johnson, Hayes & Wade (2007) **USA**	How therapists approach spiritual problems in therapy, what RS problems most common and how these are identified, diagnosed and conceptualised, how RS problems are experienced and worked with in therapy	12 psychotherapists (8 psychologists, 2 social workers, 1 counsellor, 1 marriage and family therapist) experienced in working with RS issues	Psychodynamic (5), family systems (5), eclectic (5), holistic (2), phenomenological (3), constructive-developmental (1), cognitive (1)	2 Buddhist, 2 Unitarian, 1 Episcopalian, 2 Presbytarian, 1 Disciples of Christ, 2 Evangelical Christian, 1 non-affiliated, 1 Mennonite "with new age, Pagan and other added sensibilities"	Convenience and snowball sampling	Interviews	Consensual Qualitative Research (CQR)	Extensive reflexive account. Participant validation of transcripts. Multiple analysts. Continual checking. Cross-analysis. Audit.

Study and country of origin	Aim	Participants	Therapeutic orientation	RS stance of participants	Sampling method	Data collection	Method of analysis	Methods to enhance quality
Wyatt (2002) **UK**	How psychodynamic counsellors respond (internally and relationally) when clients talk about religious faith	5 Psychodynamic counsellors	Psychodynamic	4 with religious belief (Christian), 1 without belief	Not named (Purposive)	Semi-structured interviews	Heideggerian phenomenology (other qualitative methods drawn upon)	Reflexivity. Field notes. Participant validation. Theoretical memos.
West (1998) **UK**	Explore impact of Quaker therapists' spiritual beliefs on their therapeutic practice	18 Quaker therapists (16 female, 2 male; counsellors, psychotherapists, or clinicians using psychotherapeutic skills)	Eclectic/ integrative (8), psychodynamic/ analytic (6), transpersonal/ Jungian (2), person-centred (2)	18 Quakers	Recruited via advert in Quaker publication (Convenience)	Semi-structured interviews	Moustakas Heuristics	Participant validation of transcripts. Participant endorsement of overall themes. Reflexivity.

The studies almost exclusively utilised samples from 'Western' cultures (USA, Canada, Australia and UK) although Wihak and Merali's (2005) study of Inuit culture and spirituality was one notable exception to this. Bell-Tollliver and Wilkerson (2011) also focussed upon spirituality (and kinship) specifically in relation to African-American therapists working with African-American families, therefore there was some consideration of minority groups, albeit within 'Western' frameworks. These studies highlighted to some degree how religion/spirituality is often inherently fused with broader cultural factors, and therefore it can be difficult to distinguish between these and study them in isolation. In the majority of the studies, participants represented a mixture of religious/spiritual orientations. However, overall there was some tendency towards a greater proportion of Judeo-Christian perspectives within these samples, which is arguably consistent with the populations which they represent. Four studies utilised religiously homogenous samples; West (1998) interviewed Quaker therapists and Bell-Tolliver and Wilkerson (2011), Baker and Wang (2004) and Martinez and Baker (2000) used exclusively Christian samples. The majority of studies were conducted with therapists. Only Gockel (2011), Knox et al. (2005) and Mayers et al. (2007) considered client's accounts of RS in therapy. However, these were complemented by Simmonds (2005) and Martinez and Baker (2000) who interviewed psychoanalytic/psychodynamic therapists who had also been clients and therefore spoke of their experiences from both therapist and client perspectives.

Dixon-Woods, Shaw, Agarwal and Smith (2004) highlight the complexity of assessing quality in qualitative studies. This complexity was reflected in the selected studies; overall, quality was variable, with key strengths (e.g. contribution to knowledge,

evidencing of findings) often undermined by significant weaknesses in other areas (e.g. lack of reflexivity or methodological clarity).

All of the studies utilised interview data (telephone or face-to-face). However, methods of analysis were diverse, incorporating phenomenology (5), grounded theory (3), discourse analysis (1), narrative approaches (3) and other qualitative designs (4). Some of these drew on more than one qualitative method. The main themes arising from the literature are described below and should be considered in light of the methodological issues outlined above.

Themes

Guiding principles: Ethical practice and following the clients' lead

Therapists' practice was driven primarily by strong ethical boundaries and the primary aim to promote psychological health and wellbeing (Crossley & Salter; 2005; Golsworthy & Coyle, 2001; Jackson & Coyle, 2009; Wagenfeld-Heintz, 2008). Therapists reported that they tried hard not to allow their own beliefs to shape or direct therapy (Baker & Wang, 2004; Jackson & Coyle, 2009; Johnson et al., 2007). Yet, Baker and Wang (2004) highlighted that some (religiously committed) therapists also felt inner tension as this could be experienced as denying themselves, lacking integrity in their practice, or even denying the needs/wishes of a client in order to adhere to professional standards. Jackson and Coyle (2009) also suggested that although therapists explicitly stated not wishing to change clients' beliefs, their accounts of their actual practice revealed some ambiguity in this regard, perhaps suggestive of a more

subconscious influence. It should be noted that the quality of this study was poor due to a lack of clarity and no evidence of reflexivity or any other quality control measures. Following the clients' lead was a guiding principle (Bell-Tolliver & Wilkerson, 2011; Crossley & Salter, 2005; Knox et al., 2005; Simmonds, 2005; Wagenfeld-Heintz, 2008). Wihak and Merali (2005) found that sojourning therapists working with Inuit clients were forced to immerse *themselves* within the (spiritual) culture in order to begin to understand, connect and work with their clients effectively. Learning from clients and engaging in reflective practice enabled counsellors to question their own worldviews and provide culturally attuned interventions.

Self in therapy

Therapists' practice and approach to RS was influenced by their own RS 'position' and level of comfort with the topic area (Crossley & Salter, 2005; Golsworthy & Coyle, 2001; Johnson, Hayes & Wade, 2007; Wyatt, 2002). Crossley and Salter's study with a sample of UK clinical psychologists was particularly rigorous; it had clear aims and findings and used multiple quality-enhancing methods. Two of these studies utilised samples of therapists who rated RS as important (Golsworthy and Coyle, 2001) or who had specific interest in RS (Johnson et al., 2007) and therefore may be biased. Nevertheless, all studies highlighted the importance of the therapist's own position, which either facilitated or hindered RS within therapy. In a study with religiously committed UK clinical psychologists, Baker and Wang (2004) found that participants experienced 'uncertain fusion' between their identities as Christians and psychologists; integration of these identities remained dynamic and transient; sometimes they experienced harmony between these positions and at other times experienced inner conflict. Those who indicated a greater degree of integration of their personal beliefs

with their professional role were participants with more years of experience, perhaps indicating a greater degree of comfort is experienced over time.

Some therapists were guided by their personal experiences as clients and attempted to make amends for the lack of attention or space for RS they experienced in their own therapy, by incorporating it into their professional practice (Martinez & Baker, 2000; Simmonds, 2004). Wihak and Merali (2005) noted that counsellors' experiences working with Inuit clients changed their own conceptions and openness to alternate realities, perhaps suggesting that not only does self influence practice, but practice influences self. Clients in Gockel's (2011) study perceived that their therapists' abilities to work with spiritual issues were connected with the therapists' own spiritual journey or beliefs. Whilst it should be acknowledged that this was based on clients' perspectives of their therapists, and not the therapists' own accounts, it lends support to the findings above.

Emergence of RS issues in therapy: Proceed with caution

Clients and therapists suggested that spiritual problems tended to emerge over the course of therapy; findings suggested that clients tentatively introduce these issues and monitor therapists' responses (Knox et al., 2005; Mayers et al., 2007; Simmonds, 2004; Wagenfeld-Heintz, 2008). Clients may feel uncomfortable raising issues due to fear of their therapist's response and as such, raising RS issues is construed as 'risky' and engendering particular vulnerability (Knox et al., 2005; Martinez & Baker, 2000; Simmonds, 2004). Mayers et al. (2007) interviewed clients who had received therapy in the NHS. They found that in most cases, clients' initial fears of discussing RS issues were allayed once they had experienced therapy, however, the procedure for sample

selection was unclear and it was not evident whether participants had experienced the same therapist(s) or a variety of therapists from different services. Other clients have not always found their therapists are able to work with RS in therapy. In Knox et al.'s study, although all participants reported some positive experiences of discussing RS in (secular) therapy, half also reported some unhelpful experiences and a quarter had considered raising RS in therapy at times but opted not to. Crossley and Salter's (2005) study suggests that many UK clinical psychologists were not comfortable working with RS issues and in some cases had avoided discussing these matters in therapy, or struggled to find the language to use in these discussions. This suggests that clients' concerns of receiving negative responses (or experiencing RS as dismissed within therapy) may be valid in some cases. Perceived therapist characteristics (openness, respect, understanding, acceptance) appeared to be integral, acting as facilitators to discussion if present, or barriers if absent (Knox et al., 2005; Mayers et al., 2007; Simmonds, 2004). Therapists' responses to subtle cues were highly influential in whether RS issues were discussed further (Golsworthy & Coyle, 2001). Issues were sometimes raised by therapists at assessment but otherwise may emerge, usually within the first year of therapy (Knox et al., 2005). Interestingly, in Knox's study, discussions raised by therapists were only experienced as unhelpful, although discussions which mutually emerged were experienced as helpful.

Assessing healthy and unhealthy beliefs

Assessing the health or helpfulness of RS beliefs was commonplace and a focal point of therapists' work with RS in therapy; they attempted to assess the nature of RS beliefs within their clients' lives (Golsworthy & Coyle, 2001; Jackson & Coyle, 2009; Simmonds, 2004) however there was some indication that these were understood in

psychological terms, potentially as psychological defences (Jackson & Coyle, 2009; Simmonds, 2004; Wyatt, 2002). Wihak and Merali (2005) highlighted the importance of understanding the cultural context of peoples' beliefs rather than imposing Eurocentric models of understanding. Yet clients did not want their beliefs to be pathologised or reduced to psychological theory, but understood as valid, 'worked with' and challenged when appropriate (Simmonds, 2004). When clients were able to discuss RS issues in therapy this led to more positive evaluations of therapy (Knox et al., 2005) and clients viewed faith and therapy as complementary and part of their personal/spiritual journey (Mayers et al., 2007; Simmonds, 2004). However, some therapists were uncertain how to respond when they perceived that RS beliefs were contributing to clients' difficulties (Crossley & Salter, 2005). In these instances therapists either withdrew in an attempt to respect these beliefs, tried to find an approach which maintained belief but minimised distress, or referred clients on to religious leaders.

Blurring the spiritual and the secular

The overall aim for therapeutic work was consistently cited as moving clients towards psychological wellbeing. This was addressed through utilising both spiritual and secular methods but sometimes the distinction was unclear and could overlap (Simmonds, 2004). Similar concepts were described in spiritual or secular terms (connection, resonance, intuition, transference) however it was not always clear whether there was something essentially different between these or whether the difference was merely linguistic (Golsworthy & Coyle, 2001). For example, Johnson et al. (2007) categorised the use of 'intuitive sensing' of spiritual issues as a *secular* skill yet this could also be construed in spiritual terms. Similarly, Gockel (2011) noted that clients

spoke of many of the core Rogerian features of effective therapeutic relationships, yet these were named and experienced as spiritual in nature (see Rogers 1997, cited in Gockel, 2011). It should be noted that a lack of reflexivity in this study made it difficult to assess whether a Rogerian perspective had influenced the analysis of the results or whether this finding emerged following analysis. Mayers et al. (2007) highlighted that when beliefs were worked with in therapy, clients viewed their faith and therapy as complementary and part of their overall spiritual journey, perhaps suggesting that the spiritual/secular distinction can be a false dichotomy in therapy. This was further supported by Simmonds (2004) who suggested that therapeutic shifts can have spiritual overtones and that 'transformations' can occur without psychotherapy.

RS as adding something extra

Working with RS in therapy was viewed as adding something extra to therapeutic work (Baker & Wang, 2004; Simmonds, 2004; Wagenfeld-Heintz, 2008). This may take the form of offering the therapist additional resource to enable them (personally) to manage the work or by providing them with spiritual guidance or inspiration in sessions (Baker & Wang, 2004; West, 1998). The added component may also take the form of offering spiritual practice within therapy such as prayer/meditation (Johnson et al., 2007; West, 1998) or more generally, discussions of a spiritual nature may help to bring greater perspective or restore hope in clients (Bell-Tolliver, 2011; Mayers et al., 2007). Conversely, clients in Gockel's study (2011) construed *counselling* as adding something extra to their spiritual life; when their therapists were able to witness their experience and work with it (offering understanding, acceptance, reflection) they experienced this as facilitative to their healing and spiritual growth. Interestingly, these (exclusively spiritual) clients viewed therapy as an inherently spiritual endeavour and therefore could

not construe successful therapy without this component. Notably, one participant in this study reported that the process of therapy had *initiated* an awareness of the spiritual dimension for them, despite spirituality not being explicitly discussed within therapy.

Discomfort and distancing from religion

Therapists expressed some preference for the 'spiritual' which is viewed as more inclusive and less contentious over the 'religious', which often holds negative connotations (Crossley & Salter, 2005; Golsworthy & Coyle, 2001; Wagenfeld-Heintz, 2008). Some clients also indicated that religion can have negative connotations (Knox et al., 2005). The discourse analysis conducted by McVittie and Tiliopolous (2007) triangulates with this implied discomfort with RS issues. Their findings suggested that therapists consistently used language in a way which marginalised their clients' RS issues. Their findings should be interpreted with caution as there was some indication that the authors' agenda may have driven this research and a lack of reflexivity made this difficult to evaluate. It does however highlight potentially covert mechanisms which may influence the therapeutic process and Crossley and Salter (2005) also highlighted professionals' discomfort with the topic. The tendency discussed above, for spiritual issues to be conceptualised in psychological terms, whilst understandable given the professional context, may further support this view that spiritual issues can be subverted in therapeutic settings. This may have an impact on outcomes as Gockel (2011) found that several participants reported termination of therapy which lacked 'spiritual integration' (p.162). The lack of spirituality within therapy for these clients had a negative impact on the therapeutic alliance and their therapists were perceived as more distant or intellectual. Drop-out of therapy was also reported by Knox et al. (2005) following clients' 'unhelpful' experiences of RS in therapy.

Institutional/contextual barriers

Experiences appeared to be shaped by external context and institutional factors. West (1998) found some Quaker participants experienced difficulties discussing RS issues in supervision or with colleagues. Several participants in Crossley and Salter's (2005) study with clinical psychologists emphasised the absence of RS issues within their training. The power of 'professional culture' is perhaps emphasised as several participants noted they had not thought about or discussed RS issues throughout their subsequent careers. Simmonds (2004) highlighted that several psychoanalysts had been rebuked during training for raising spiritual issues with their analysts, whilst others experienced less explicit disapproval but found that spiritual issues were ignored and they had learned to address spiritual interests outside of therapy. Some had been grateful that their analysts had been more respectful and they had experienced psychoanalysis as helpful to spirituality. Baker and Wang (2004) and Martinez and Baker (2000) both highlighted that their (Christian) therapist participants exercised personal caution disclosing their beliefs to colleagues due to fear of negative judgement. The latter also highlighted that participants had experienced training courses as 'disinterested', 'dismissive' or 'anti-' religion, suggesting therapists were within a professional atmosphere which was perceived as predominantly hostile towards RS. A minority of participants cited positive experiences whereby consideration of RS issues by their trainers was supported however, notably, these were with individuals who held religious beliefs, perhaps emphasising again that the position of the 'self', mentioned above, influenced practice. Martinez and Baker's study had a clear aim and the findings were well evidenced, however it was a short paper and consequently limited in detail. They reported using grounded theory for the analysis, however there was no evidence of

reflexivity, a lack of clarity around sample selection and, most pertinent in relation to grounded theory, there was no mention of theoretical sampling or saturation of data. The quality of this study may therefore be limited.

Wyatt (2002) also highlighted the importance of organisational context in shaping the therapists practice, however he chose to use 2 ‘paradigm cases’ (p.178) to illustrate the results and thus it is difficult to ascertain whether this particular finding was consistent, or based upon one participant’s account. Whilst some studies cited ethical/professional guidelines as a helpful and guiding principle in therapists’ work (Baker & Wang, 2004; Jackson & Coyle, 2009; Wagenfeld-Heintz, 2008), there was also an indication that such guidelines could be constraining to practice. For example, Baker and Wang (2004) suggested that therapists experienced tension when they felt unable to respond to a client’s spiritual request. The expectations of their job role also at times evoked discomfort due to a clash with their personal values.

Discussion

These findings are situated within a broader context of client care. It is recognised firstly that whilst many clients have voiced a desire for their spiritual beliefs to be incorporated into their care, one should not assume that this is the preference of all individuals. Secondly, clients accessing MH teams may have their spiritual needs met by other professionals and not necessarily wish to discuss these matters within psychotherapy. However, this is an area which is potentially rife with tension for both client and therapist, yet also holds great promise for client resilience, growth, wellbeing and the therapeutic alliance and outcomes. The findings of the current review clustered

around the following eight themes: Ethical practice and following the clients' lead as guiding principles; the self in therapy; emergence of RS issues in therapy; assessing healthy and unhealthy beliefs; blurring the spiritual and the secular; RS as adding something extra; discomfort and distancing from religion; and institutional/contextual barriers. The limitations of this review are outlined below and the findings discussed in relation to their implications for research and clinical practice.

Methodological limitations

The aim of this review was primarily to describe rather than synthesise the data, therefore it was not a meta-synthesis. However it should be recognised that the review represents a 'third order' perspective of the data, as it is an evaluation of the authors' understanding of the original participant data (Shaw, 2012). With this distance from the data, a certain element of error is unavoidable and this may mean that some of the thematic areas drawn out are misrepresentative; nonetheless the primary focus of this review was to identify, critique and summarise the extant literature.

Although not all studies within this review included participants with RS beliefs, the findings may have been naturally influenced by a sampling bias, with those more interested in the topic more likely to participate and thus over-represented. Therefore the experiences of other therapists and clients who were less inclined to participate remain unknown. There was an over-representation of Judeo-Christian perspectives which may limit the transferability of the findings. In addition, it is important that results are evaluated in context; even within 'Western' societies, there are wide cultural variations and faith and mental health practices differ. Findings from the USA and UK, for example, may therefore not be comparable.

Implications for research and clinical practice

This review supports previous research which suggests that therapists' practices are guided largely by the personal experience, beliefs and comfort of the therapist (Shafranske & Maloney, 1990). As Crossley and Salter (2005) suggest, training programmes should consider taking a reflexive (rather than didactic) approach to spirituality, enabling therapists to consider and query their own views and latent assumptions. This may be complemented by increased opportunities for discussion and work with people who hold different perspectives. These approaches may help to foster a more open and exploratory atmosphere at the organisational level, which is receptive not hostile to RS issues and where difference is valued, not stifled.

Individual therapists should be encouraged to engage in ongoing reflective practice in relation to RS and discuss these issues in supervision in order to maximise their confidence and competence in addressing RS issues in practice. Given the propensity for therapists to assess the 'health' of their clients' RS beliefs, they should be aware of their own prejudices and values which may exert influence on these evaluations. Wihak and Merali's (2005) study was unique in being the only study where therapists were working within a foreign culture where RS was considered by the majority, rather than a minority of clients. It is possible that therapists became more aware of and willing to reflect on their own RS stance and alternative perspectives when they found themselves within a minority position.

In Rose et al.'s (2001) study, only five percent of clients indicating that they wanted to discuss RS in therapy wanted to do so due to its relevance to their problems. Most

commonly cited reasons for endorsing RS in therapy were due to it being regarded as "essential for healing and growth" (27%), "personally important" to them (22%) and central to their personality, behaviour and worldview (15%). This highlights the potential centrality of spiritual beliefs on individuals' identity and worldviews (Joanides, Joanning &Keoughan, 2000). The findings from this review that therapists are keen to assess the health of RS beliefs, whilst professionally appropriate, may highlight a potential disparity between clients' and therapists' motivations for discussing RS in therapy, however without further research, this remains speculative.

The therapeutic relationship is complex and whilst it is evident that RS beliefs of the client, therapist, or the interaction of both, can influence the therapeutic endeavour, Worthington et al. (1996) suggested that this can be for better or worse. They also highlighted that clients modify their behaviour and intimate disclosures in therapy, based upon their perceptions of the therapist's beliefs, which may impact on therapeutic process and outcome. This is supported by the findings of this review, which suggested clients' approach to RS in therapy tended to be tentative and cautious.

Whilst the findings highlighted that there may sometimes be discordance between clients' anticipatory fears or perceptions of their therapist's response to RS belief and their actual subsequent experience, it is important to bear in mind that these fears may act as a barrier in therapy. This is consistent with literature which recognises the therapeutic alliance as a stronger predictor of therapeutic outcome than specific treatment modality (Asay & Lambert, 1999). Threats to the therapeutic alliance may lead clients to drop out of therapy, or lead to poorer outcomes and therapists failure to attend to clients' preferences within therapy may constitute one such threat to the

alliance (Swift, Callahan & Vollmer, 2011). The evidence from this review that RS issues were not always welcomed by therapists and that some clients with negative experiences of RS in therapy reported terminating their therapy suggests a need for therapists to develop greater cultural competence and demonstrate to clients an openness to working with RS amongst other diversity issues. Whilst one approach may be for therapists to raise RS as part of their assessment (as advised by the Department of Health, 2009 and Worthington,& Sandage, 2001) there is limited evidence from the current review as to how this is experienced by clients. The indication from Knox et al. (2005) that RS issues when raised by the therapist were experienced as unhelpful is difficult to interpret in isolation as it may be associated with therapists imposing their own beliefs or judgement. Clients consistently reported being enabled to discuss RS issues when they experienced their therapist as accepting, respectful, and understanding. Whilst more research is needed, therapists may benefit from exercising some caution, paying particular attention to clients' reactions to spiritual assessment and utilising their clinical judgement. Focussing upon establishing a good therapeutic alliance before RS issues are explored in detail may also be beneficial. Assessment may allow therapists to model openness to RS and facilitate discussion of clients' beliefs, which could in turn enhance the therapeutic alliance.

It is important to recognise that these findings relate to clients who have *entered* the therapeutic setting and had the opportunity to discuss (or not) their RS beliefs. There may be many more potential clients who do not access therapy. Many people with RS beliefs may seek help or counselling from a faith community rather than health services (Mitchell & Baker, 2000; Cinnirella & Loewenthal, 1999), or opt for therapy with a recognised religious component. Several religiously adapted/integrated therapies within

mental health have emerged based on both 'Eastern' and 'Western' traditions and reviews of these are beginning to materialise (as noted in the introduction). However, many clients may not be informed about these, or may not choose or have access to RS adapted therapies. Particularly in NHS settings, due to limited resources, clients are likely to have little choice regarding the type of therapy available, or the therapist they work with. As such, the need for clients to be able to approach RS issues with any therapist, should they wish, remains. Clients may fear, or have experienced, negative attitudes or a lack of understanding of RS from health professionals (Baker, 2010). Within psychology, there has been a historical split between influential theorists who recognised and emphasised a spiritual aspect of being (e.g. William James, Abraham Maslow, Carl Jung) and those such as Sigmund Freud and Albert Ellis who viewed RS as illusory and a sign of psychological ill-health (Moreira-Almeida et al., 2006; Nelson, 2009). In addition to the predominant scientific discourse within health settings, the perceived Freudian legacy within psychology is one explanation of why clients may be cautions of raising RS in therapy and fearing their beliefs may be dismissed or even pathologised. These fears, whether well-founded or not, may act as barriers to accessing services, with the potential for those with RS beliefs to become marginalised groups within mental health settings.

The tendency highlighted in this review for spirituality to be explained in psychological terms perhaps highlights that psychological constructions hold greater power than spiritual ones. Dura-Vila et al. (2011) found a mismatch between (religious) psychiatrists' beliefs about the importance of RS in client care and their actual practice. Their paper focussed on general psychiatric practice, not psychotherapy, and was therefore excluded from the current review, nonetheless, they reported that both UK-

born and migrant psychiatrists from a range of faith traditions endorsed the value of RS belief in mental healthcare. Yet they censored their practice in favour of a purely 'scientific' approach. This was particularly pronounced for migrant psychiatrists who expressed a disparity between their native practice and UK practice, where they felt a pressure to take a medical stance, influenced by the fear of other professionals' responses and the General Medical Council. Yet, ironically, Moreira-Almeida et al. (2006) highlighted that some of the earliest hospitals were founded and run by religious organisations or priests. Greater recognition of the historical and current contribution of religion/spirituality in (mental) healthcare may help to redress the power imbalance between religious and psychological dialogues within research and clinical practice. Further research with clients is needed in order to consider how clinical practice may better include spirituality as a potentially active component of routine person-centred care. From a UK perspective, given the predominance of the NHS in healthcare, further research with NHS service-users and therapists of their experiences would be informative and enhance the transferability of qualitative findings. Given the potential response bias in qualitative research, large-scale quantitative surveys of current practice nationally, may help to contextualise this evidence. Further qualitative studies with homogenous samples from different faith perspectives may highlight similar or different experiences and would enrich our understanding.

In the current review, it appeared that therapists who personally value or have interest in spirituality may find ways of incorporating this into their routine practice, yet still experience difficulties with this at times, for example, hesitating to raise issues in supervision or fearing colleagues' responses. In the secular setting, the scientific domain still holds precedent and there is some indication that spirituality is, at best

tolerated or worked with inconsistently or at worst, avoided or sidelined. The literature consistently highlighted the influence of organisational factors and the professional atmosphere on therapists' practice. This suggests that to facilitate change, therapists need to be considered within context and change needs to be addressed both at an individual and systemic level.

Given that many individuals with mental health difficulties may choose to seek help from faith communities, or therapists may choose to 'refer on' when RS difficulties arise (Crossley & Salter, 2005) research with religious leaders may be helpful to explore their experiences of working with mental health difficulties in the context of faith. This may also be one way of beginning to redress the imbalance in the therapeutic/spiritual dialogue, empowering faith leaders' by bringing their voice to the fore.

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Section 2

Research Report

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

Abstract

This qualitative study utilised Interpretative Phenomenological Analysis to explore the experiences of clergy providing pastoral care to support people with their mental health. It also explored their experiences of interacting with health professionals. Eight Christian clergy were purposively sampled and semi-structured interviews conducted. Three super-ordinate themes emerged: (1) *Connecting with a person not a problem: The provision of holistic care* outlined the whole-person approach adopted by clergy and the multifaceted nature of the care offered, incorporating practical, emotional, social and spiritual provision. (2) *Power differentials: "Together we can solve it"* highlighted participants' desire to cooperate with services which were often experienced as difficult to access. The influence of power was explored. (3) *The influence of boundaries* reflects participants' use of boundaries and the personal impact of their role. Whilst further research is required, the findings suggest that the influence of power should be recognised in order to guide future practice.

Key words: clergy**,** mental health, pastoral, collaboration, religion, spirituality, IPA

Introduction

Religion, spirituality and mental health

In 2006, the Mental Health Foundation (MHF) published a review of the United Kingdom (UK) literature evaluating the impact of spirituality on mental health (Cornah, 2006). Acknowledging the limitations of the evidence and some contradictory findings, they concluded a consensus of 'cautious optimism' about the role of spirituality in the promotion and maintenance of mental health (p.32). Reviews of multi-national literature also support these findings (Koenig, 2009; Moreira-Almeida, Neto & Koenig, 2006). Spirituality may exert its effect through coping styles, locus of control, social support, lifestyle factors or the physical environment, yet the possibility of a potential 'non-empirical' divine influence has also been acknowledged (Cornah, 2006).

Although spirituality and religion have been recognised as difficult to define, there is a distinction between the two concepts. Spirituality is a broader term encompassing the search for meaning, and connection with the self, the environment and others, as well as transcendent aspects of being (MHF, 2007). Religion is a narrower term relating to particular sets of beliefs or values, usually shared by a group of persons, following the teachings of a divine leader or deity (Koenig, 2009). Those who do not affiliate with a religion may still have spiritual beliefs/needs (MHF, 2007; Worthington, Hook, Davis & McDaniel, 2011).

The importance of considering religious and spiritual (RS) perspectives within healthcare has received increased attention, due to the possible health benefits outlined above, but also recognising it as a potential area of discrimination. Religion/belief is now one of nine protected characteristics under the 2010 Equality Bill and services are obligated to make efforts to reduce health inequalities that may arise in relation to this

(DoH, 2011). Recommendations have been made that mental health (MH) services should build effective links with faith communities and address spiritual needs in order to deliver effective care (Cornah, 2006; DoH, 2009a; DoH, 1999). Worthington, Kurusu, McCullough and Sandage (1996) speculated that changes in the health care system in the USA might lead to more people seeking counselling from the voluntary sector and clergy. Although contexts differ between countries, the current political and financial atmosphere suggests a similar shift in the pattern of help-seeking may emerge in the UK (DoH, 2011). The importance of MH and collaboration with health services is also reflected in documentation produced for the church (Tidyman & Seymour, 2004).

In addition to political drivers, there is a theoretical context to support working with faith groups. Community psychology theories seek to move away from individualistic approaches towards a psychology which situates the individual within their community (Orford, 2008; Trickett, 2009). It draws upon systems theories, group dynamics and social support, but is underpinned by Lewin's field theory (Lewin, 1951, cited in Orford, 1992). This proposes that individual behaviour is a function of both the person and their 'field' or environment. Lewin highlighted the importance of a holistic approach when working with individuals, recognising behaviour and identity to be partly determined by the groups that people affiliate with. Working within this milieu may therefore be particularly important. Religious beliefs may influence an individual's self-concept, values and world-view as well as their immediate social context. Acknowledgement of the person-in-context is perhaps more readily recognised in collectivist cultures than in 'Western cultures' where individualism predominates. For example, Bell-Tolliver and Wilkerson (2011) recognised the utility of a multi-systems approach when working with African American clients that enables the extended family

(which may include spiritual communities) to be considered as the part of the therapeutic endeavour.

Service-user perspectives

In addition to the drivers mentioned above, a stream of user-led research published by the Mental Health Foundation from 1997 onwards (cited in MHF, 2002; 2007) consistently highlighted that spiritual needs are important to service-users. Service-users reported wanting RS to be recognised in their care yet also reported that they have experienced health professionals (HPs) as being uncomfortable or avoidant in discussing such matters. It has been suggested that this might be due to a range of factors, including lack of training, personal beliefs, or a perceived incompatibility with traditional science, medical models, and evidence-based practice (Cornah, 2006; MHF, 2007; Moreira-Almeida et al., 2006). A study of clinical psychologists' experiences of addressing spiritual needs with clients highlighted numerous factors which may serve as barriers (Crossley & Salter, 2005). Spirituality was highlighted as an elusive concept and often culturally sensitive and uncomfortable to discuss. Some therapists may have had negative personal experiences of religion or view it as insignificant, potentially preventing it arising, or being actively 'worked with'. Crossley and Salter warned of the danger that respecting clients' spiritual beliefs might lead to overlooking them. Yet, there has been some historical recognition within psychology (particularly within the humanistic field) of the spiritual aspects of being. Some empirically-supported therapies even have their roots in traditional religious practices, for example mindfulness-based approaches borne out of Buddhist meditation (Kabat-Zinn, 2003). Reviews of RS integrated therapies and treatment programmes have emerged (Smith, Bartz & Richards, 2007; Worthington et al., 2011). The findings of these reviews were

limited by the methodological weaknesses of the studies included, and potential publication bias, however they tentatively suggested that that RS therapies produced equivocal and sometimes superior outcomes to non-integrated therapies, although effects were greater on general wellbeing and spiritual outcomes than psychological outcomes.

Help-seeking

There is evidence from the USA that those experiencing mental distress will seek help more frequently from clergy than from HPs (McMinn, Chaddock, Edwards, Lim & Campbell, 1998; Wang, Berglund & Kesler, 2003). These findings may be culture-specific, as a European survey (which excluded the UK) showed significant differences between countries and overall lower rates of help-seeking from clergy than the USA (Sevilla-Dedieu et al., 2010). Whilst there appears to be less UK research of this nature, Cinnirella and Loewenthal (1999) found that over half of their UK multi-faith sample (including those with and without experience of MH difficulties) thought that seeking help from a holy person would be appropriate in relation to MH difficulties. Leavey (2008) and Leavey, Loewenthal and King (2007) also noted that faith-based organisations, strongly rooted in the community may be the first point of contact for those experiencing MH difficulties, particularly in Jewish and Islamic communities. Whilst support from the religious community may be accessed by many people with mental health difficulties, others may fear stigma from their faith communities (Baker, 2010; Weatherhead & Daiches, 2010). In effect, people with RS belief may be vulnerable to a 'double dose' of stigma; from health services in relation to their RS belief and from faith communities in relation to their MH (Baker, 2010).

Research with clergy

There have been few studies within the UK exploring the practices and experiences of clergy/church leaders[1] in relation to mental health. More research has been conducted in the USA (McMinn et al., 1998; Worthington et al., 1996), who found that referrals tended to be uni-directional, from clergy to mental health professionals (MHPs), and that clergy were more likely to refer if they knew that MHPs shared their beliefs and values. However due to differing cultures, pastoral systems and healthcare practices, these findings are not necessarily transferable to other populations.

Guthrie and Stickley (2008) interviewed six clergy regarding their understandings of mental distress and spiritual experience. Data were analysed thematically. The sample, drawn from a MH education and awareness forum, was biased as all participants had a special interest in MH, therefore their understandings may differ from other clergy. The authors highlighted the need for more inter-professional teamwork between clergy and MHPs, due to clergy's specialist knowledge of spiritual issues and their impact on MH, although the study did not explore such collaborations. They suggested that both professions needed to be willing to learn from each other, to recognise the 'unknown' and take an open-minded approach to broaden knowledge about the many possible origins and expressions of MH difficulties.

Leavey (2008) and Leavey, Loewenthal and King (2007) conducted interviews with nineteen Christian, six Jewish and seven Muslim male clergy working in London. Both papers appear to have used data from the same sample, which was heterogeneous and large for a qualitative study. The methodologies for these studies were unclear and they both seem to have drawn upon a number of different qualitative techniques (e.g.

[1] The terms 'clergy' and 'church leaders' will be used interchangeably throughout this document.

grounded theory, phenomenological and thematic analysis). The lack of clarity generated difficulties in evaluating the quality of these studies and their contribution to the knowledge-base. Leavey (2008) highlighted that MH pastoral care differs between faith groups and also *within* religions. Differences were noted between 'mainstream' and Pentecostal Christian churches on a conceptual and pragmatic level. Although attitudes towards secular care and implications for collaboration between MH and pastoral systems were discussed, this was not the focus. The author summarised that the article merely 'touched the surface' of the many 'complexities that may face service providers as they seek collaboration with clergy'(p. 101). Leavey et al. (2007) focussed on the discernment of illness, MH training, pastoral care and clergy contact with MH services. They found that there was a perceived lack of recognition of the role of clergy in pastoral MH care by their training bodies and by statutory services and as such they lacked confidence in managing this aspect of care. Anxiety, fear and stereotyping of mental illness were evident in their accounts. They acknowledged willingness among clergy to refer but there appeared to be a focus on attitudes towards referral rather than the practice and experience of referral and collaboration. The authors recommended that more research was needed on how MHPs can engage with clergy, and the type of care that clergy feel able and willing to offer.

Two questionnaire studies were conducted with clergy in relation to MH care (Foskett, Marriott & Wilson-Rudd, 2004; Lawrence et al., 2008). Foskett et al. explored the attitudes, experience and expertise of 68 (Christian) religious leaders and 89 MHPs in Somerset, England. They found that the majority (73%) of clergy had referred to HPs on more than four occasions (usually within primary care) and only 7% had never referred. By contrast, 61% of MHPs had never made a referral to clergy. Lawrence et al. (2008) surveyed 237 NHS hospital chaplains regarding the provision of pastoral care

to elderly in-patients with MH needs. The most commonly cited reasons for requesting spiritual support were for counselling (47%) and in relation to terminal illness (37%) compared to only 6% requesting prayer. Both of these studies lacked methodological rigour and the use of questionnaire data prevented detailed exploration of individuals' experience. In addition, Lawrence et al.'s focus on inpatient services, elderly MH and the sample of hospital chaplains limited the generalisability of the findings. Given that relatively few people with MH difficulties access inpatient services and the shift towards community-based care (Leavey, 2008), there is a need to further explore pastoral support provided by community clergy for people with MH problems within their faith communities.

In summary, there appear to be only a few studies in the UK that have examined the experiences of clergy in providing pastoral care and these are limited by both sample and methodology, as described above. There are however suggestions, from policy, theory, and research, that further collaboration is needed between faith communities and MH services. Yet little is known at present about what is happening in practice at the interface of faith-based and health care. It seems clear then, that there is a need to explore this further, in order to guide the delivery of spiritually-sensitive MH services.

Aims

This study aims to explore community-based Christian clergy's experiences of providing pastoral care and supporting people with their mental health. An additional aim is to explore clergy's experiences of interacting with the UK mental healthcare system.

Method

Consistent with the aims of the study, a qualitative design utilising Interpretative Phenomenological Analysis (IPA) was employed, as outlined by Smith, Flowers and Larkin (2009). This method enables in-depth exploration of individual lived experience. It seeks to understand how people perceive and make sense of their experience, whilst also recognising the influence of the researcher in forming this understanding (Biggerstaff & Thompson, 2008; Smith, 2011).

IPA has three main theoretical underpinnings: Phenomenology, hermeneutics and idiography (Larkin & Thompson, 2012; Smith et al., 2009). Phenomenology concerns the nature of experience; IPA seeks to understand how a person perceives and experiences their environment and themselves within it. Hermeneutics is derived from the study of religious texts and refers to interpretation (Nelson, 2009; Smith et al., 2009). In IPA it is recognised that the experience of another can only be accessed through interpretation and hence IPA contains a double hermeneutic; the researcher interprets the participant's own interpretation of their experience (Smith, 2011). The interpretative process is multifaceted, cyclical and dynamic and data is analysed as a whole and in parts. Finally, IPA is idiographic in that it is concerned with the individual and the particular. It involves detailed analysis of individual cases and recognition of patterns and nuances in the data (Biggerstaff & Thompson, 2008).

Procedure

Recruitment

To ensure a degree of homogeneity within the interview sample, participants were purposively sampled according to inclusion criteria outlined below. Homogeneity is important in IPA because it enables an exploration of experience from the perspective

of a particular group of people, and for exploration of patterns of convergence and divergence in their experiences (Smith et al., 2009). Eight participants were recruited via a multi-denominational Christian charity. A recruitment letter (Appendix iii-a) was sent via email and post. Recipients were encouraged to distribute the information to other clergy who might be interested; hence, it was not possible to be certain of the overall population sampled.

To enable purposive sampling for the interview, those who expressed interest in the study completed screening questions online (Appendix iii-b). Participants were selected in accordance with the following inclusion criteria:

- Community-based Christian church leaders. Including both those formally ordained and 'lay leaders' with pastoral care roles.
- Experience interacting with health professionals.
- English-speaking.

Thirty-eight people completed the initial screening questions[2]. Those who indicated interest in participating in an interview and who met the inclusion criteria were provided with information sheets and consent forms (Appendix iii-d and iii-e respectively). Those who agreed to take part were contacted by email or phone to arrange the interview. The first eight participants to indicate they were willing to take part were interviewed by the researcher in either their home address or place of work. Participants were given the opportunity to ask questions before providing written consent to participate.

[2] Following online screening, all respondents were invited to complete an online survey (Appendix iii-c) which aimed to elicit quantitative data in order to contextualise the qualitative findings. Due to an extremely poor response rate (estimated at 6%) this data was later excluded from the study as it was not considered representative of the sampled population.

Participants

Participants were eight Christian clergy (5 male, 3 female) aged 39 to 56 (mean=46, SD=5) from South Yorkshire, UK. Further demographic data of participants and their respective churches are presented in Table 1.

Table 1.

Participant and Church Demographics

Participant Demographics	
Ethnicity	White British (7) White Irish (1)
Ordination status	Ordained (6) Lay (2)
Years of experience in church ministry	Mean=16.6 years (Range=3.5 to 30 years)
Prior hospital chaplaincy experience	No (4) Yes (4)
Experience interacting with health professionals	A little (5) Moderate (1) A lot (2)
Occupational history	Full-time ministry (1) Prior experience in other field (7) (Including: nursing, civil service (2), youth work (2), computer programming, sales, media, personnel, probation, alcohol rehabilitation)
Highest educational achievement	GCSE (1) BA/BSc degree (4) Diploma (2) Masters (1)
Personal denomination	Anglican/Church of England (4) Baptist (2) Methodist (1) Assemblies of God (1)
Church Demographics	
Size (average weekly attendance)	Median=55 (Range 20 to 350)
Catchment	Urban (2) Suburban (5) Rural (1)
Denomination	Anglican/Church of England (4) Baptist (1) Methodist (1) Assemblies of God (1) Wesleyan Reform (1)

Data Collection

Semi-structured interviews were conducted following a topic guide with associated prompts to be used as required (Appendix iii-f). Four topics were covered: (1) Participant's role in pastoral care, (2) Experiences supporting people with their mental health, (3) Experiences interacting with HPs when supporting the MH of those in their community, (4) The outcome or impact of this work. The interview schedule was constructed by following guidelines suggested by Smith et al. (2009). This was revised following discussions with the research supervisor and piloted with a lay leader in pastoral care. The schedule was effective in eliciting relevant data and feedback was positive, therefore no further changes were made.

Interviews lasted between 60 and 90 minutes and were audio-recorded. Following the interview, participants completed a demographic information sheet (Appendix iii-g). Participants were debriefed following the interview and asked if they wished to be informed of the findings. Immediately following the interview, the researcher made notes relating to the process and content of the interview, any initial impressions and issues to be discussed in supervision. Audio-tapes were then transcribed by the researcher or a University-approved transcriber.

Analysis

The transcripts were analysed in accordance with the IPA methods outlined by Smith et al. (2009) and Larkin and Thompson (2012). Transcripts were read alongside the audio-tape to check for accuracy, and to facilitate immersion in the data. Notes about the researcher's initial response to the interview data were kept to allow 'bracketing off'

and help maintain focus on the data (Smith et al., 2009). The data was read again and analysed from linguistic, descriptive and conceptual perspectives. Notes were written in the margins identifying key words, points of interest, meanings, values, processes and events described in the clients account.

Emergent themes were identified and written in the left hand margin. By reflecting both the participant's description and the analyst's interpretation of this, these themes seek to capture a *shared* understanding of the data. The themes for each transcript were listed, then revisited and condensed where possible. Field notes were also revisited during analysis to remind the researcher of the process issues which arose during interview. A map was produced for each transcript, plotting the main themes (see Appendix iii-h for extracts from the analysis process). Connections between themes were then explored, both within and between participants, and themes were grouped in order to extract super-ordinate themes. These were checked with the original transcripts to ensure they were evidenced within the data. Super-ordinate themes were established according to frequency, prominence and conceptual fit.

Ethical considerations

Prior to commencement, the research proposal was subject to an internal review. Scientific approval was granted by the scientific review panel and ethical approval from the Department of Psychology Research Ethics Committee at the University of Sheffield (Appendix ii-a). Governance approval and sponsorship were obtained from the University of Sheffield (Appendix ii-b). Brinkmann and Kvale (2007) highlight that ethical research depends more upon the development of ethical principles and behaviour in the researcher, than following a list of procedures. The researcher's responsibilities were therefore borne in mind throughout the research process, amid formal ethical

procedures. Recognising the unpredictable nature of the data which emerges from interviews, consent was regarded as a process rather than an event and participants were informed of their right to withdraw consent following the interview (Allmark et al., 2009).

Quality control

Whilst recognising the need to ensure quality with qualitative research, several authors have warned against a 'checklist' approach (Barbour, 2001; Spencer & Ritchie, 2012). Quality was considered throughout the research and informed each stage of the process; from design to dissemination (Smith et al., 2009; Larkin & Thompson, 2012). However, quality assurance procedures also took place to enhance rigour.

One coded transcript was read by the research supervisor. Coding, themes, and any discrepancies were reviewed and discussed in supervision. One further un-coded transcript was read independently by the research supervisor, and his interpretation of the data and initial impressions of the main themes were noted. These were then compared with the researcher's preliminary notes and themes to cross-check agreement and discuss any discrepancies. In addition, the researcher regularly attended a qualitative research group and utilised this as a source of peer-supervision. A peer-audit also took place; the paper-trail of the analysis of one transcript was conducted to verify that the outlined procedures could be followed and that the emergent themes could be traced back to the data.

An important aspect of qualitative research is acknowledgement of the integral role of the researcher in the interpretative process. The scientific endeavour is traditionally associated with objectivity, stemming from a realist position which regards reality as

fixed and therefore amenable to observation and accurate definition (Guba & Lincoln, 1994). This does not fit with the epistemological stance of IPA which holds a more critical realist position. IPA in particular maintains an interpretive perspective, recognising multiple realities which are fluid and determined by inter-subjective and contextual factors (Shaw, 2010). Thus, in qualitative research the demand for objectivity is replaced by the need for reflexivity. Whilst researcher subjectivities arguably influence *all* research to some degree, in qualitative methods the researcher is close to the data and entwined within the process (Kidder & Fine, 1997). Therefore researchers are acknowledged as part of, and a 'tool' within the research. This necessitates a level of transparency, so that their interaction with the data can be fully explored and considered (Kidder & Fine, 1997; Shaw, 2010; Smith et al., 2009).

In order to ensure the researchers' own experiences and attitudes were acknowledged and did not have an undue influence upon the findings, a reflexive log was kept throughout all phases of the research; from conceptualisation to completion.

The research team comprised the researcher who regarded herself as holding a spiritual position. She was baptised into the Church of England as a baby and attended church on occasions during childhood. As an adult, the researcher identified with and was practicing the Christian faith, although this was not associated with any strong denominational affiliation. She had experienced a number of churches with Anglican, Baptist, Methodist and independent affiliations. The research supervisor identified with an agnostic stance and regarded himself as spiritual but sceptical with regards to religion. Both were psychologists working in clinical settings with people with MH difficulties. The researcher did not have any experience working alongside clergy in relation to clinical work, however had informally interacted with clergy outside of work

and in relation to designing this research. The research supervisor did not have experience working with clergy directly, however had encouraged clients to seek support from their faith leader. Interest in the topic of this research was largely borne out of reflections upon the interaction of the researcher's personal and professional experience. The researcher recognised firstly that faith and spirituality can be integral to some individuals' worldview and lifestyle. Yet the researcher's experience was that these issues rarely arose in therapeutic encounters. The researcher also noted personal apprehension in disclosing personal religious/spiritual beliefs within a professional setting which was perceived as predominantly atheistic and where the dominant discourse was scientific.

The researcher's position as a MH professional was explicit within the information provided prior to interview, however participants were not informed of the researcher's religious/spiritual position. It was noted that participants' perceptions of the researcher (both professional and religious) may have impacted on the process of the interviews.

Consistent with the hermeneutic aspect of IPA, the researcher is required to enter into a dynamic process of engaging with and interpreting the data as a whole and also in parts. The process of reflexivity was therefore ongoing, allowing continual consideration of how the researcher interacted with the data on a macro and micro level.

Results

Data were analysed in relation to the key aims of the research. The themes which arose from the data encompassed both of these aims; they will therefore be discussed collectively. Table 2 outlines the super-ordinate themes which emerged and the sub-ordinate themes incorporated within these.

Table 2
Super-ordinate and sub-ordinate themes

Super-ordinate themes	**Sub-ordinate themes**
1. Connecting with a person not a problem: The provision of holistic care	i. "Being with", safe listening and the spiritual element. ii. Location, accessibility and ongoing relationship iii. Connection and inclusion
2. Power differentials: "Together we can solve it"	i. Clergy eager to cooperate but disabled by distant and disinterested services ii. Organisational and relational power
3. The influence of boundaries	i. Role distinction and fusion ii. "Managed availability"

Theme 1: Connecting with the person not the problem: The provision of holistic care

Despite variety in the structure and context of participants' roles, the desire to provide holistic care was evident. Participants' Christian values were occasionally made explicit but in many cases appeared to be implicit in their work. Participants' appeared to be motivated to care for others and offer provision where there was unmet need. Hence, their work was not only shaped by individual and societal needs, but by the nature of local service provision: where services were limited or unavailable, participants stepped in to fill the gap.

> "We offer food, clothing, place to, you know, shower, laundry, basic skills education, dentistry, chiropody and mental health services...we used to offer a GP

but actually because of the greatly improved access to GPs in the town centre now since the drop-in centre opened...we don't need that as much" [HARRY][3]

"A lot of the NHS staff won't pick up home visits, other than the District Nurses who are very over stretched so they're happy for me to do a lot...of the picking up of the isolated people who are either depressed or housebound..." [AMELIA]

Participants' practice appeared to be both person-centred and needs-led. As such, the scope of their care was vast incorporating practical, financial, social and emotional support as well as more specific spiritual care.

"I don't think you can do one without the other to be honest with you, so I mean going away and praying for somebody is all well and good but if you leave them hungry, or...poor, I just don't believe that that is what Jesus would have taught so we try and make sure that *practically* they are okay and then emotionally and spiritually...if there is anything we can do for them." [BOB]

"She was complaining that the ghost of her daughter was there...so I went round and prayed in her house, to ask the blessing of God really to be in that place and spent some time trying to help her talk through the terrible angst of losing her child." [AMELIA]

1i. "Being with", safe listening and the spiritual element

Participants offered the opportunity to be alongside individuals in dealing with their difficulties. They described seeking to provide a safe place, listening, accepting and attempting to see beyond the immediate to the core of individuals' difficulties. This

[3] Pseudonyms have been used throughout in order to safeguard anonymity of participants. Extracts have been edited to enhance readability [...] denotes edited extracts.

practice parallels to some extent psychotherapeutic principles and can be seen to contain non-specific elements of therapeutic practice.

> "What he does need sometimes is just someone who isn't going to make any judgements, you know, who is just going to sit there..." [WENDY]

> "[The priest] receives as a witness, thus really witnesses, other people's lives and an awful lot of what I offer is thoughtful, safe listening and then either putting what's been voiced into a religious context of meaning...or referring on to someone who can explore the experience more deeply." [HARRY]

Participants also offered specific spiritual interventions. These interventions sometimes reflected the professional role of clergy, as people sought specific intervention *from* the participants, for example, requesting anointing or blessing by the priest. Other interventions were more participatory and the participants were alongside the person, guiding them through spiritual acts.

> "If somebody finds thinking difficult or overwhelming, developing simple things like lighting a candle as a prayer, you know, 'at the moment we'll say all the words, all you can do is light a candle once a day...and if you can, think of God loving you and all the other people who love you and just be grateful for that...they can bring who they are to God and have a sense that that's accepted" [HARRY]

The spiritual element of holistic care was viewed as complementary to traditional healthcare rather than an alternative or preferential intervention.

"...so I think...within my competence counselling is something I should be adding into this mix as the, as the person who has some care for these people spiritually and holistically" [WENDY]

"I suppose ultimately I am just hoping that I am bringing some form of wholeness alongside all the other health care professionals and I certainly see it as a collaborative thing, I don't see it as a either/or..." [AMELIA]

1ii. Location, accessibility and ongoing relationship

Participants' physical location and social presence within the community was reported as providing people with easy access to support when needed. Participants expressed that this availability could be perceived as constant and unlimited. This sometimes led to difficulties for participants and is a tension that is discussed in Theme 3 below. Some participants noted that the timeliness and immediacy of response was particularly important and the implication was that this was unique and not something on offer from statutory services.

"It was one of those things where you have no idea what the person's said to you on the phone but you know the only thing you need to do is get in a car and get to them" [WENDY]

"I think they also know that in some way we're, we're there for people….they do see us as perhaps the only, erm, recognisable professionals now actually who do live in the place where they work...the doctors, teachers...very often once they've finished doing what they're doing, they're gone whereas...we're always there" [GEORGE]

The value of participants' accessibility was also reflected in their accounts which suggested it enabled them to know people within the context of their whole lives; the participants spoke of their roles in a way which often extended beyond the individual to the wider family or community and their relationships were seen to have a history.

> "I know [her] mum, I knew [her] mum as a teenager" [WENDY]

> "I can think of another older man who also had paranoid schizophrenia and was a *regular* churchgoer for nine of my ten years, who would stop taking his medication at times and we would begin to suspect...and we would be saying 'I haven't seen him for three weeks...I'm concerned'" [JUDITH]

Crucially, knowing people over time provided participants with a sense of not only connection but also an understanding of the issues, as they appeared to have tacit knowledge of peoples' lives by virtue of knowing about the context in which they lived.

> "I suppose because you have the beauty of a longer term relationship I can generally be saying 'oh six months ago you were in a very different place than now and you are really, really coming on and it's great to see.'" [AMELIA]

The participants' added insight was something which services were perceived to lack and participants had the potential to help provide a fuller picture by offering their perspective to services.

> "I notice enormous needs based around depression and sadness...there's an enormous need there and that's just...curiously hidden, but not hidden from clergy because we have I think uniquely the very, very elderly actively involved in the community in a way that they're not involved in many other organisations" [HARRY]

> "I've been dealing with one person for a long, long time and, and at various points she's refused to access...the NHS side of things so we'd been, you know, me and someone else had been the only kind of lifeline for that" [WENDY]

Wendy (above) talked about being the 'only kind of lifeline' for this individual. This indicated the uniqueness and significance of their role implying that there would have been nobody else there for this person. The term 'lifeline' also emphasises the critical nature of participants' work in a life or death sense. This may be understood figuratively, as merely a linguistic emphasis on the importance of the role. It could also be understood literally; for some people, not having the participant there may have resulted death as the outcome.

> "I suppose the kind of good stories are where they will literally say I'm pivotal in helping them still be alive and I have had a few people say that." [AMELIA]

However the extent of individual and societal need was often vast and participants expressed the personal burden of maintaining the position described above.

> "I think in that particular area I generally feel very overwhelmed because it's just such a needy area. I just feel quite despairing sometimes, I come away thinking 'oh my goodness what can *I* do' erm and I pray a lot (LAUGH) and I go to the gym for an hour's blasting off of all the rubbish that I have encountered" [AMELIA]

The emphasis on 'I' perhaps reflects the participant's own sense of responsibility, desire to help and perhaps a sense of personal insignificance or powerlessness in proportion to the overwhelming need. The participant talks about coming 'away', which highlights only a partial identification with the community and the ability to create distance and

remain separate from those in the greatest need. 'Blasting off all the rubbish' is a powerful image of the potential sticking power of the unmet need and the strength of desire to be freed from it and be restored.

1iii. Connection and inclusion

Many participants spoke of the importance of encouraging inclusion into a wider community and Harry, below, explicitly linked this to Christian principles. It was seen as important for churches to be welcoming and inclusive and for pastoral care to be accessible to all people, regardless of faith, age, health or social status.

> "I would say that what the core...*strongly* Christian value is being someone of worth, whoever we are we're worth something...and everyone has a place in our community....Now that's about as strongly as our *explicit* Christianity is because we've Muslims, Pagans...Jains, Buddhists, and people of no faith tradition at all or strong, strong atheists access [church]. It's very important to us that *that* is honoured." [HARRY]

Participants spoke of their role in connecting people on individual, community, organisational and spiritual levels. This was often through facilitating practical social connections and involvement.

> "So sometimes I would be mediating really…just trying to paint the picture of another human being and sometimes trying to introduce people who had something in common where they tended to see paranoid schizophrenia, big notice (LAUGH) rather than to understand that actually they have common experience." [JUDITH]

> "It's just a kind of community initiative that takes place here, it's a chance for the elderly to get out of their home, to mix with each other" [BOB]

There was also a spiritual aspect of connection. As part of their more specific role, participants facilitated or encouraged connection with God through prayer, acts of worship and symbolism. This transcendent aspect seemed to be offered to individuals to provide ongoing connection even in the absence of others.

> "He [God] goes with you from this place so there is that sense of, you know the Therapy or the getting well doesn't just happen in the time me and them spend together it actually carries on when they walk out that door and I suppose it is giving them the tool, to say 'and you can pray for God 24/7, you don't need me to do it for you'...it is kind of a 24/7 prescription...I think somehow the prayers, I don't know, touch them in a different way, in just a different way than using human contact." [AMELIA]

Theme 2: The influence of power differentials: "Together we can solve it"

A picture emerged of clergy and health services operating in parallel, both on separate paths yet aiming for the same 'destination', with little communication en route. This links with the findings in Theme 1 of the participants' holistic role being complementary to healthcare but perhaps illustrates a chasm created by different models of care and organisational systems. The potential for health and religious professionals to work more optimally in collaboration than they do in separation was illustrated by the nature of the power held by each.

2i. Clergy eager to cooperate but disabled by distant and disinterested services

Participants frequently expressed a desire to work in collaboration with services, despite difficulties in communication and the perceived differences in roles, there was recognition of common ground.

> "It's something about the NHS and church ministers, vicars actually can have a key role to play and should be at certain times considered to be professionals with whom it's *appropriate* to discuss the mental health of people within their care...what are we trying to achieve? We are trying to achieve the wellbeing of the patient." [BEN]

> "I wanted to help the guy and support him, but at the same time I didn't want to step on someone else's toes...I wanted to work in partnership really" [GREGORY]

Services were often experienced as difficult to access. Consequently, participants remained distant or excluded from statutory services. This distance was reflected in the nature of participants' accounts which sometimes became vague and hypothetical, or related to incidents that had happened a long time ago. Participants were left guessing why support was inaccessible. Disinterest, suspicion of clergy, lack of trust, protocols and confidentiality were some suggested reasons.

> "I recognise patient confidentiality and I think that is *so* important….but there is a protocol that says a CPN and a Psychiatrist can have a chat, a GP and a Psychiatrist can ...but obviously I'm employed by someone different. The Minster and the CPN can't have a chat." [BEN]

Some participants disclosed their frustration with services and also spoke of their need for advice or intervention from HP's recognising the limits to their own expertise. These limitations created a tension with their broad and almost limitless job description to help those in need.

> "I was really desperate for some good advice as to what to do in that situation because it was...one that I just wasn't really qualified to deal with" [GEORGE]

Difficulties were particularly evident in crisis situations when support was most urgently required. Some participants perceived that their insights or perspectives were often dismissed by health professionals. The impact of this was poignant and these accounts were often delivered with heightened affect, added emphasis and use of emotive language.

> "When she came in he was kind of sitting there with a carving knife with the children and *still* we struggled to get anyone to realise how bad he was" [WENDY]

Ben spoke of how the poor response from the NHS in one crisis situation had resulted in the church excluding somebody due to the level of risk they posed to the congregation. This course of action directly conflicted with the values of care and inclusion and caused further tension.

> "What happened, I, and this is, I had to ban her...and that for me that is heartbreaking because we are supposed to be the community that welcomes...but this woman is the only person in ten years that I have banned from coming on a Sunday." [BEN]

To counter the lack of engagement from services, participants spoke of using informal contacts for support and guidance.

> "I do have a phone-a-friend, as it were, psychiatrist" [HARRY]

> "I've found it very helpful to have a former Mental Health Nurse come around, who still takes an interest and…just being able to check out my own perceptions...with somebody that can give me that professional input." [JUDITH]

2ii. Organisational power and relational power

A latent theme within participants' accounts was that of the power held by the NHS. This was reflected in the examples of communication and referral practices between participants and HPs which were often experienced as one-way; instigated by participants but with no reciprocal interaction from services.

> "I don't on the whole experience referral from Health Professionals, I think…if that has ever happened to me, that's rare." [JUDITH]

> "I asked to speak to the CPN because I was really, really concerned as I had been trying to persuade the woman to go and seek help. She hadn't done and I thought now there needs to be some form of intervention and I was not allowed, they would not even *tell* me, unless I could name the CPN….so I left my concerns and I heard nothing else back from them, no feedback, no phone call to say it's been actioned, that we have passed it on and that is, this is the frustration…" [BEN]

The difference made when health professionals *did* work collaboratively was noticeable and participants spoke positively about these occasions when they occurred. More often, but not exclusively, these positive experiences were associated with participants who were 'known' or had relationships with local services, highlighting the importance of relational power.

> "The practice nurse...was a friend long before I found out she was a practice nurse...so there is a really good two way relationship and...GPs have regularly said to [patient] 'you are still talking to [Wendy] aren't you?'...so there is an appreciation there equally from them that I have a role." [WENDY]

> "When I have gone and met with people and health professionals face-to-face, whether it was the Psychiatrist, GP or CPN, that has been positive because I have had a sense that they are interested in what support I am giving to the patient. That is positive. It's also been a tremendous learning experience because...I see how health professionals operate with people with mental health issues which is *great* because...I have had no training." [BEN]

Ben's recognition of his lack of training suggests a more subtle power differential, also reflected by other participants who alluded to lacking expertise. Participants' accounts sometimes reflected powerlessness. This may be because they feel their potential is not optimised or they lack the training or skills to be fully effective.

> "I was feeling that...the opportunities arose where I could play an active part, and where I was asked to play an active part, but it was just not knowing how to or where to or what....I could have done with some guidance really." [GREGORY]

> "Sometimes you feel you just can do nothing, I know I have talked about what I have done and what I have tried to do, sometimes you just feel 'there is nothing I *can* do really' and is just a matter of being with people and while you know that that *is* the only thing that you can do it still sometimes feels very frustrating...." [BEN]

Ben's quote may also reflect an element of recognition of personal limits; that despite participants' passion and vocation to help people, in some instances they have to accept that they cannot help, and tolerate the emotional discomfort this evokes. During the course of the interviews, participants sometimes re-framed their experiences in de-spiritualised terms, perhaps in an attempt to be taken seriously, by speaking the language of HPs. This might demonstrate a perception based on their experience that MH practitioners might be sceptical about religion.

> "Well I suppose in psychology terms I would almost see it [prayer]...like a way of summarising at the end that I have heard what they have said...so I think it works on a psychological level." [AMELIA]

> "...you know we are normal people, we are just here to care for the community" [BOB]

This was also reflected in an example given by Ben, who suggested to a member of the congregation that they ought to try to express their difficulties "perhaps in a way that the doctor can understand". Other participants spoke of peoples' inherent trust of HPs, again reflecting the power that they hold. Amelia alluded to an almost omnipotent role of the NHS, emphasising the power and authority of the organisation.

"If I planned to justify my existence to PCTs I would probably have a harder time"

The extent of participants' sense of frustration and disempowerment in relation to the health service was reflected in the following dialogue.

P "Yes, let's get this flow of information sorted out so that we can at least be briefed, so, well, say that I or other people in my situation know that we are listened to and can be given appropriate advice, guidance, support in helping patients, yes.

I And how do you think that might happen?

P (SIGH) Miracle? I think we need a miracle. (SIGH)" [BEN]

Reflexivity: I became aware that although I viewed my position primarily as "the researcher", I was also a representative of the NHS. In conversation with participants I frequently felt the strength of their frustration and a pull to respond in some way, especially when a thread was emerging through the research about communication with the NHS being "one-way". I felt I needed to hold the boundary of my role as a researcher, yet this did not rest well personally or ethically; I felt that through the relatively one-way flow of information through the interviews (i.e. hearing/receiving their accounts) I was reinforcing their experience of HPs as being withholding and maintaining more power within the relationship.

In contrast to the organisational power of the NHS, the participants spoke in way that indicated that they held relational power. This is reflected in the *ongoing relationship* described above (Theme 1ii). Participants' flexibility, responsiveness and social positioning within their community perhaps allows greater influence in peoples' day to day lives than HPs may have.

"I first of all was very wary that I was going to contradict something and do damage to this guy...." [GREGORY]

"These days, because...this is a twenty-year relationship, you know...what generally happens is her boyfriend who I know quite well will send a text saying '[Wendy], [girlfriend] refusing treatment again, she's bad, can I bring her to talk to you?'" [WENDY]

Some participants indicated there was divine relational power through their relationship with God. God may guide them personally in the day-to-day elements of their work, or be a powerful presence they can connect with and draw upon when working with people.

"I would equally say sometimes God prompts us to do things and, you know, that doesn't mean I hear God's voice in my head, I don't...(LAUGH) but, you know, I do sometimes feel that names pop into your mind because, there's a reason" [WENDY]

"I always pray with people because I am a great believer in the power of prayer" [BEN]

Reflexivity: Although none asked me directly, many of the participants seemed curious about my spiritual positioning. I felt that several participants attempted to gauge my stance by asking about my motivation for the research, or alluded to their uncertainty about my beliefs within the interview with phrases such as "whether you believe in this kind of thing or not, God spoke to me" [Amelia]. Jaspal (2009) notes the complexities of the 'insider'/'outsider' dynamics which influence the dialogue between participant and researcher. Participants may have made assumptions about my stance, which may have influenced their approach to discussing RS within the interviews – perhaps resulting in extra caution, or feeling the need to reframe things within logical [Wendy] or psychological terms [Amelia/Harry] in order to validate their work, or even work harder to explain to me the value and reality of their faith [Bob/Gregory].

Theme 3: The influence of boundaries

Participants spoke of the personal impact of providing the holistic care described in Theme 1. Participants used boundaries, to differing degrees, in order to manage their role.

3i. Role distinction and fusion

Sometimes ambiguities in role boundaries emerged as an interview progressed. This is illustrated by one participant who, uniquely, worked within a primary care setting. This person expressed a clear role boundary early in the interview:

> "I will refer them for counselling if I feel that it is beyond my remit because there is a danger sometimes of being in Primary Care that they try and make you into a counsellor so I have to keep reminding them that I am not a counsellor"

They then later expressed acceptance at taking on this previously rejected role:

> "I kind of accept that I am being seen as a Counsellor, a substitute Counsellor and the only thing I will say to them is 'I don't necessarily have the training to back it up but I am willing to listen and I am prepared to work with [people]'"

Some participants remained very clear about the limits of their role which was associated with a professional boundary and served to maintain a comfortable distance from their work.

> "I always wear my distinctive professional dress when I'm working, and obviously I never wear it when I'm not working...it's very helpful when my

work is so diffuse, of indicating to me when I'm in role and when I'm not in role and indicating to others." [HARRY]

The expansive nature of participants' roles, their ongoing relationships with the community and the provision of needs-led care often revealed blurring of roles. For example some participants spoke of relationships which resembled friendships, perhaps influenced by a Biblical model of the nature of care.

"I wanted to be effective in helping him....I saw him as much of a friend as a....it wasn't like I was the minister and he was the person in the pew sort-of-thing...." [GREGORY]

"I know she's on Facebook because I'm a friend of hers on Facebook" [WENDY]

The accounts above may represent a fusion of the personal and professional identity. Participants' differed in this regard and whilst this fusion was resisted by some, who emphasised and maintained the professional boundary of their role, for others, the personal and professional were less distinct and they appeared to accept that in order to do their job, their personal life would also be affected.

P Well to be honest anything goes...you know being a Minster...it's a really interesting vocation...because it's not a nine to five....the only time I can switch off is if I am on vacation.

I What's that like for you?

P Oh it's fine, you have just got to learn to adjust..." [BOB]

Although the level of need and weight of individuals' difficulties had an impact on participants, several also recognised the personally rewarding element of their role.

> "To be with people in their most difficult circumstances is a privilege. It never ceases to amaze me...when you are there with people and they are sharing their deepest needs and their most painful moments with you and it is profoundly moving and a privilege...I find it, yes, incredibly awe inspiring really." [BEN]

Some participants clearly separated MH from their role, viewing this as outside of their competence and an area for health services to manage. This may be viewed as an attempt to distance themselves from mental health difficulties due to fear, or in an attempt to maintain a limit to their role. It also suggests that despite their holistic approach, some clergy view mental health as different to general wellbeing or spiritual health and recognise a need for specialist services to address this.

> "If I feel fairly assured that that person...is already getting the help that they need from say, a doctor, mental health professional or whatever, erm, then I would feel I could offer them if they needed it something supplementary to that that...but if they weren't...I would want to try to channel them very strongly towards that as soon as possible rather than getting embroiled in something that I wouldn't feel qualified to deal with." [GEORGE]

> "He said 'oh I don't need to see a Doctor, I just need prayer'...I said 'well yeah, there's nothing wrong with you, spiritually, I mean if there was then prayer would do it, but, you know there is no healing, you just need a *boost'* so I said 'you need to contact your GP...'" [BOB]

Yet the overlapping nature of spiritual and mental health care was also acknowledged. Many participants anticipated this and viewed this as a valid part of their role.

> "I am working more on the spiritual things but it inevitably crosses over with mental health stuff." [AMELIA]

> *"A lot* of people who come for [confession] are people with mental health problems, saying they feel ashamed of something or they've done something wrong and, quite an element of the priest's task is to help work out, well is it or isn't it a sin, *feeling terrible* isn't a sin, might be suffering but it's not a sin, and helping people explore that...but if somebody *has* done something major that they feel very troubled by...actually *naming* that and absolving the person can be quite an important stage on the way to wholeness and to integrating the whole of themselves back into a secure place of health" [HARRY]

Participants recognised the potential for MH problems to be masked by spiritual explanations and looked beyond supernatural understandings or spiritual presentations of distress to more natural explanations.

> "I am the kind of liberal that tends to assume that most disturbances in the home are human rather than [spiritual]…but I would never say never, equally." [JUDITH]

3ii. "Managed availability"

Some participants described feeling isolated, vulnerable and needing to protect themselves at times, which may imply a gap in provision from their own employer. However the inadequacy of support experienced from health services could be seen to compound this sense of isolation and participants were left carrying the burden (see Theme 2).

> "I do think that there is a great reassurance though in knowing that there is somebody that you can talk to when you're, er, embroiled in a situation like that and that you're not having to deal with it just on your own because...speaking from experience it's absolutely exhausting and, er, at times quite frightening." [GEORGE]

Harry spoke of providing "managed availability" which could be viewed as an attempt to manage care-for-self and care-for-others, as other participants spoke of times when their work intruded into their personal lives.

> "I can remember instances when I would invite somebody in and then think 'how am I ever going to get rid of them?' (LAUGH) Or, you know the conversation started out being reasonably safe and but then I started to get worried (LAUGH), and I would be much more likely now to keep someone on the door step and leave the door, and lock it, if I went away to get food or something so they couldn't come in." [JUDITH]

> "...sometimes they...ring at eleven o'clock at night and it doesn't do well for your marriage." [AMELIA]

Some participants recognised the importance of boundaries not only in order to manage the extent of peoples' needs and participants' own availability, but also as a mechanism of effective helping. Boundaries (of time, space and responsibility) were viewed as protective and facilitative but also as potentially restrictive.

> "I make a certain amount of time available and then I will pace when I'm available in the future... I'd almost always meet in a, erm, safe space where other people were around." [HARRY]

> "Minsters don't have tight boundaries, whereas often the NHS is absolutely screaming with boundaries and I think that there are plusses and minuses to both....and I think you have a lot of burnt out Ministers who don't know how to put any boundaries in and I think you have some NHS health care professionals that can't do diddly squat because some rule has said they can't and that is a real shame." [AMELIA]

As well as striving to encourage the individual autonomy of those seeking support, collective responsibility for pastoral care within the wider community also helped participants to manage the demands of their role. This is consistent with theme of *connection and inclusion* (1iii) above. Therefore, whilst a shared responsibility may help clergy feel less isolated, vulnerable and overwhelmed, it also benefits individuals as they experience relationships with and acceptance from others in the community.

> "There are a couple of other men, his similar age, that have taken an interest in him, which is great because that has taken some weight off me but it also says to the person that there is other people that care about you, that will support you, that don't judge you." [BEN]

Discussion

The findings of this study suggest that participants offered holistic care in order to support individuals with their MH. Their approach appeared to be person-centred and inclusive. Participants suggested that they stepped in to areas of unmet need, perhaps

driven by the Christian values which influenced their practice[4]. They recognised the strengths and limitations of their roles and yet spoke of the inherent tensions of being available to offer care to those in need whilst managing the personal impact of this (also noted by Leavey et al., 2007). They recognised the importance of the wider community in supporting mental health and part of their role was in facilitating participation and inclusion. Participants expressed a desire to work collaboratively with MHPs in order to support individuals more effectively. Statutory services were frequently experienced as difficult to access and this had an impact on participants who at times were left disempowered and burdened, personally and professionally. Participants managed this in different ways; some placed a greater importance on maintaining professional boundaries whilst others' personal/professional roles were less distinct. Collaboration was viewed positively and the role of HPs and those providing pastoral support were viewed as complementary, rather than conflictual.

The findings of the current study which used a homogenous Christian sample support the findings of Leavey et al. (2007) and Lawrence et al. (2008). Leavey et al.'s theme of *contact and intimacy*, converges to some degree with the current study's subordinate themes of *location, accessibility and ongoing relationship* and *connection and inclusion* as part of holistic care. Notably, Leavey et al. discussed 'intimacy' as a barrier to care as participants had expressed the lack of anonymity associated with this as potentially preventing help-seeking. This was not highlighted by the participants' in the current study and may to some degree reflect the religious and cultural diversity within Leavey et al.'s sample. Holistic elements of care were also noted by Lawrence et al. (2007) whose participants recognised *presence* and *affirmation, reconnection and*

[4] Appendix iii-i contains an extract from the Anglican liturgy for the ordination of priests which provides some insight into the official role of clergy.

normalisation as positive aspects of pastoral care. Thus, it seems that whilst these holistic elements have been expressed differently between studies, there is a good degree of triangulation suggesting that this may be a core aspect of pastoral care, which is common despite the nuances of individuals' roles and working contexts.

The current study's theme *the influence of boundaries* also converges with Leavey et al.'s (2007) themes of *vulnerability* and *professional role boundaries*. In both studies, differences were noted between participants in their approach to the boundaries of their role, however most participants in the current study seemed to indicate a greater degree of comfort in their pastoral work than in Leavey et al.'s study where there was a strong dialogue around clergy fear and discomfort in working with MH issues. Again, this may reflect differences in the samples and participants' working contexts, or could be influenced by researcher characteristics (the lack of reflexivity within Leavey et al.'s study makes this is difficult to assess).

Limitations

This was an idiographic study, therefore the results were not intended to be representative of all Christian clergy. Many of the participants had limited experience of working with services and their accounts were retrospective, therefore not only influenced by their interpretation of their experience, but their interpretations over time. The use of a homogenous sample, an idiographic method (IPA) and provision of contextual information allows the reader to assess the transferability of the findings to other contexts (Meyrick, 2006; Smith et al., 2009). The diversity within and between different Christian traditions should be noted: Distinctions have been made in the past between beliefs and practices in Pentecostal and 'mainstream' Christian churches (Leavey, 2008). The acceptance of the need for 'secular' MH intervention was

associated with more mainstream Christian and liberal Jewish clergy in Leavey's study (p. 100). Only one participant in the current study was from a Pentecostal church (Assemblies of God) however it is possible that others shared some Pentecostal beliefs. Similarly, there were no participants in the current study from the Catholic church, therefore similarities and differences in experiences from this other 'mainstream' perspective have not been explored.

The sample may represent clergy with greater personal interest or experience relating to the topic than the clergy who did not volunteer and this inherent response bias should be recognised. The views and experiences of clergy with less awareness or interest in MH may differ. It is also possible that those who experienced health services as particularly difficult to access may have been more motivated to participate, viewing it as a valuable opportunity for dialogue with a MH professional. Purposive sampling of clergy who had experience interacting with HPs, whilst consistent with the aims of this study, provides no insight into the experiences of clergy who have never interacted with health services. Therefore the voice of this important group remains absent from this research.

The use of focus groups to gather data may have been beneficial and these have been used in IPA research (e.g. Whittaker, Hardy, Lewis & Buchan, 2005). The power held by the MHP researcher may have diminished, as the researcher's position within the dialogue may have been less prominent amid a group of clergy than in a one-to-one interview. A group would have allowed discussion between participants, therefore the degree of agreement or disagreement with each other would potentially be explicit rather than inferred entirely through the process of analysis. However, individuals' accounts may also have been unduly influenced by group dynamics and social pressures

and opportunities to probe for depth may have been limited (Smith et al., 2009; Whittaker et al., 2005).

Implications for research and practice

The findings of this study provide additional novel insights into pastoral care and clergy interactions with health services. The participants' experience of one-way interactions with HPs is consistent with previous findings that clergy are more likely to refer to MH services than vice versa (Foskett et al., 2004; McMinn et al., 1998; Worthington et al., 1996). Further research, exploring the views and experiences of HPs may help to explain this finding. Whilst it could be argued that clergy have greater *need* for the particular expertise of MHPs, these findings may suggest a lack of recognition by HPs of the skills and expertise of clergy, and the value of their role in the community. Equally, it may reflect the impact of organisational barriers. Interestingly, Leavey (2008) found that the role of Imams had been "increasingly overlaid with duties and functions related to community political leadership, acting as mediators between the local and state authorities" and they are "called upon" to sit on health committees and intervene in community disputes (p.94). This perhaps suggests that the role of clergy is recognised in situations when statutory services require a cultural consultant for minority groups, rather than for their contribution to health and wellbeing in itself.

Whilst the power between clinician and client has often been recognised, this research highlights that the organisational influence of the NHS extends further. The NHS appeared to hold power within the relationship between health services and clergy, and had the potential to either inhibit or enhance their functioning in MH pastoral care, which has important implications for practice. Managers, policy-makers and clinicians may need to pay greater attention to the power they hold in relation to whole

communities, not just individual clients, shifting away from an individualistic model of care to a more community-focussed perspective. Systemic interventions which enhance the skills of individuals and their immediate support network, alongside wider community initiatives may be beneficial.

The DoH (2009b) highlighted an aim to **"**create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities." (p.12). The recent UK 'Big Society' agenda suggested community empowerment, public service reform and social action as three key strands in the aim to improve mental health outcomes (DoH, 2011). The findings of the current study indicate that clergy are already active in this process and are positioned to facilitate this further, through their location in society and their focus on inclusion, connection and social action. This links with previous research which has recognised clergy as frontline MH workers (Leavey et al., 2007; Oppenheimer, Flannelly & Weaver, 2004).

Crucially, the message from participants was not simply that they were willing to collaborate with services, but that they *needed* services at times, in order to maximise their own potential and the wellbeing of those they support. Yet, the findings imply that services (and clients) may also need clergy as they meet needs not met by statutory services. A combination of the accessibility, flexibility and relational power held by clergy could be viewed as complementary to the organisational power and specific health expertise held by the NHS and its clinicians. This suggests that both the NHS and clergy could be more effective if they worked collaboratively rather than in parallel. This is consistent with the notion of collective action to facilitate health and social change within communities recommended by Murray and Campbell (2004), who also highlighted the need for 'grassroots' communities to build alliances with agencies

which have the power, structure and finances to enable change. Interventions which fail to recognise the interdependencies within and between wider systems, may inhibit progress or amplify problems. The findings also support Guthrie and Stickley's (2008) recommendation that MHPs and clergy may benefit from taking an open-minded approach, willing to learn from each other and valuing differing views and explanatory models. Training programmes encouraging MHPs to engage in reflexive practice may be beneficial to enhance MHP's awareness of their own implicit values and enabling them to explore these differing views. Joint training initiatives or conferences in which both professions can share their perspectives and expertise may also be beneficial and facilitate the formation of relationships (Edwards, Lim, McMinn & Dominguez, 1999).

Overcoming barriers

Whilst differing values and viewpoints are one potential barrier to collaborative practice (Edwards et al., 1999; Ranade & Hudson, 2003) the current research suggested clergy viewed their roles as harmonious to the NHS, recognising a shared goal. Clergy and MHPs may benefit from identifying their commonalities and allowing this to guide their work together, as this may reduce the impact of any differences which arise. Ranade and Hudson (2003) recognise that attempts at collaboration may be unlikely unless there is an indication of *mutual* gain. The current findings suggest that there is a potential for mutual gain between HPs and clergy. Although the altruistic common goal of improving the wellbeing of a person is important, given the increasing resource limitations, focussing on mutual *professional* gains may hold greater immediate incentive and facilitate the formation of collaborative relationships.

In view of public service reforms which encourage partnership with outside agencies, charities and social enterprises (DoH, 2011), there is a need for service managers to

consider the organisational barriers to collaboration. Adapting policies to permit and encourage clinicians to recognise clergy as fellow care professionals may be beneficial. Including clergy routinely in clinical practice (when appropriate) and in collaborative research may be one step towards redressing the power imbalance, ensuring RS is not sidelined within healthcare. Positive examples of contact with HPs in this study were usually associated with existing relationships, therefore creating opportunities for clergy and HPs to build relationships may foster more cooperative alliances. Yet, consistent with community psychology theories (Lewin, 1951, cited in Orford, 1992), clergy and HPs also exist within context. It is therefore essential to acknowledge complex organisational forces which may add additional challenges to the change process. Ranade and Hudson (2003) highlight that continual changes in public policy have led to contradictory modes of governance within services, creating difficulties in developing cohesive management strategies. They suggest that policies which encourage collaboration may be difficult to implement within organisations that are operating within target-driven, competitive frameworks.

As participants' experience in this study suggests that they meet unmet need, demands on clergy may increase as statutory services become more stretched and societal needs outweigh resources. Many clergy in this study indicated a personal impact and burden of their work supporting others. This could be managed to some degree by providing appropriate support and supervision to clergy, to reduce their isolation, equip them to support peoples' mental health, and lead their church communities in doing the same. Some support may be offered by their governing bodies, however specialist support and consultation may be required from MHPs. Worthington et al.'s (1996) recommendation that psychologists have a role in forming collaborative alliances with clergy to support them in the areas where they may lack expertise therefore seems apt.

Future research is needed into the experience of clergy from other faith traditions, as experiences may vary due to differing cultures, belief systems and organisational and societal contexts. However, there may also be pertinent commonalities and therefore research in this area would enable further triangulation of findings. National quantitative surveys (conducted with clergy and with NHS staff) assessing current practice, views relating to collaboration and motivation for change would be beneficial, enabling contextualisation of qualitative findings. In addition, qualitative studies with MHPs relating to their views of clergy roles in relation to MH, their experiences of collaboration and any perceived barriers to joint-working would complement the current findings and further inform future policy and practice. Further research with service-users would also be beneficial, for example studies exploring service-users' experiences of clergy and HP support through the care pathway.

Conclusions

This study provided a detailed exploration of clergy's experiences of providing pastoral care to support people with their MH and their experiences of interacting with HPs. The findings suggest that the provision of holistic pastoral care was viewed by participants as complementary to statutory MH care. However, in order offer effective care, and to manage the demands of their work, participants sometimes required communication with or specialist support from MHPs, which was often experienced as difficult to access. This had a personal and professional impact on clergy. Support was most easily accessed through existing relationships and this was viewed as beneficial. The findings highlight that the power held by HPs and the NHS extends beyond the individual to their community context. The Department of Health (2011, p.17) recognises that the people around an individual can help support the implementation of HPs advice. It also highlights that the delivery of care extends beyond the individual therefore professionals have a role in working with others to respond to the wider needs of a person and their family. A holistic view of the care pathway, which considers individuals within their environment is consistent with community psychology theories (Lewin, 1951, cited in Orford, 1992). The current research suggests that clergy may be well placed to support and reinforce interventions, signpost individuals to health services and promote positive MH in their communities. Whilst further research is needed, a greater focus on community perspectives and systemic interventions may help services to provide more effective holistic care in collaboration with others.

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Section 3

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Appendix i

a) **Journal approval letter**

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

21st February 2011

Sarah Wonders
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Sarah

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Mental Health, Religion and Culture

Research Report: Mental Health, Religion and Culture

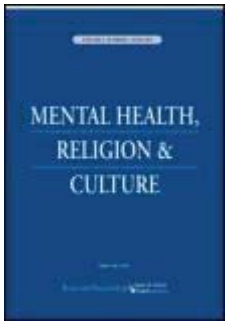
Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Dr Rebecca Knowles
Research Tutor

Appendix i

b) Notes for authors



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Instructions for Authors

SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

The instructions below are specifically directed at authors that wish to submit a manuscript to ***Mental Health, Religion & Culture***. For general information, please visit the Publish With Us section of our website.

Mental Health, Religion & Culture **considers all manuscripts on the strict condition that they have been submitted only to** ***Mental Health, Religion & Culture*****, that they have not been published already, nor are they under consideration for publication or in press elsewhere. Authors who fail to adhere to this condition will be charged with all costs which** ***Mental Health, Religion & Culture*** **incurs and their papers will not be published.**

Contributions to ***Mental Health, Religion & Culture*** **must report original research and will be subjected to anonymous review by independent referees at the discretion of the Editorial Office.**

Manuscript submission

Manuscripts for consideration should be submitted via the ***Mental Health, Religion & Culture*** ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site, submissions should be made via the Author Centre. Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to reviewers. When uploading files authors will then be able to define the non-anonymous version as "File not for review."

Papers that specifically concern **psychiatry, anthropology, medicine and sociology** should be directed to Dr Simon Dein.

Papers that specifically concern **psychology and religious studies** should be directed either to Professor Kate Miriam Loewenthal, or Dr Christopher Alan Lewis. If in doubt, papers can be directed to any Editor.

Authors are invited to nominate up to two referees (not from their own institution) although it is not guaranteed that they will be consulted.

Books for review

Books for review should be directed to Dr Christopher Alan Lewis via the online ***Mental Health, Religion & Culture*** Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

For queries regarding book reviews, please contact Dr C.A. Lewis at: School of Psychology, University of Ulster at Magee College, Northland Road, Londonderry BT48 7JL, Northern Ireland (tel: +44(0)2871 375301; fax +44(0)2871 375402)

Manuscript preparation:

1. General guidelines

- Papers are accepted English. British English spelling and punctuation is preferred.
- A typical article may be between **5,000** and **10,000 words**. A short article for rapid publication will not exceed **2,000 words**. Papers that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendices (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- An abstract of no more than 150 words is required for all papers submitted.
- Each paper should have between three and seven keywords.
- The title page should include the title of the paper, all the authors' full names, affiliations, postal addresses, telephone and fax numbers and email addresses. One author should be identified as the Corresponding Author at the bottom of the page. An abbreviated title should also be given, for running headlines within the article.
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- Description of the Journal's article style, Quick guide
- Description of the Journal's reference style, Quick guide
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We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each figure should be numbered with Figure number (Arabic numerals).
- Figures must be saved separate to text. Please do not embed figures in the main document.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
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Please note that it is in the author's interest to provide the highest quality figure format possible. Please do not hesitate to contact our Production Department if you have any queries.

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Tables should be numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

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Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

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Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. The actual tables and figures should be supplied either at the end of the text or in a separate file as requested by the Editor. Ensure you have permission to use any figures you are reproducing from another source. Advice on artwork is available here.

Running heads and **received dates** are not required when submitting a manuscript for review.

If your article is accepted for publication, it will be copy-edited and typeset in the correct style for the journal.

If you have any queries, please contact us at authorqueries@tandf.co.uk, mentioning the full title of the journal you are interested in, or see our Author Services homepage.

Appendix ii

a) **Ethical approval**

------ Forwarded Message

Date: Thu, 24 Jun 2010 09:51:26 +0100

To: <G.Rowse@sheffield.ac.uk>

Subject: Approval of your research proposal

Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals. " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,

Prof Paschal Sheeran

Chair, DESC

------ End of Forwarded Message

Appendix ii

b) Governance approval

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

6th June 2010

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals
Investigators: Sarah Wonders (DClin Psy Trainee, University of Sheffield); Dr Georgina Rowse, Dr Andrew Thompson (Academic Supervisors, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it, and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

Dr. Rebecca Knowles
Research Tutor

Co. Sarah Wonders, Dr Georgina Rowse, Dr Andrew Thompson

-------- Original Message --------

Subject: Your project in URMS, 128956, has now been authorised

Date: 14 Jul 10 14:50:30

From: noreply@sheffield.ac.uk

To: C.Harrison@sheffield.ac.uk

Project code: 128956

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals (Sarah Wonders)

This project has now been checked and authorised by the Research Office. Relevant details can now be transferred to any application forms or documentation. Please note that you should use figures from a project report with the status COSTING APPROVED to ensure you have the finalised figures.

Please note that staff named as Principal Investigator or co-Investigator on the "Investigators" page of the URMS record can access the costing and can, therefore, necessarily see the salaries of staff costed on the grant. Staff salary information is only made available for the purpose of calculating the cost of an application, is strictly confidential and should not be discussed.

Should you have any queries relating to the costs, please contact the URMS helpline on 21450.

GUIDANCE ON URMS PROJECTS AT THE "COSTING APPROVED" STAGE

1. Research applications require Institutional authorisation before submission to the funder. Completed hardcopy applications should be either mailed or dropped off at the Research Office (via the "Research Applications" mailbox) together with any requisite supporting paperwork such as procurement forms or letters of support, and contact details for any queries.

Applications with a full economic cost value less than GBP 750,000 received before noon on any working day will be available for collection by noon the following working day. Applications received after noon will be available by 5pm the following working day. Applications can be returned to departments via mail if required.

Applications with a full economic cost value greater than GBP 750,000 require four days for authorisation due to the availability of the small number of authorised signatories above this amount.

Please note that these timescales also apply to electronic applications.

2. If the Department of Health's "Research Governance Framework" is applicable to the project and external or additional funding is not being sought, e.g. "own account" or student research projects, the project will not be moved to APPLICATION AUTHORISED until the Research Office has received written confirmation of which organisation is the project's Research Governance sponsor.

3. There are several web resources available to staff on the Research Office website, including:

Information regarding University processes for research costing, applications and contracts at: http://www.sheffield.ac.uk/researchoffice/overview/contract.html

Guidance on Research Governance, Clinical Trials & Ethics (and access to the Good Research Practice Standards) at: http://www.sheffield.ac.uk/researchoffice/gov_ethics_grp/governance

General advice and guidance regarding research applications at: http://www.sheffield.ac.uk/researchoffice/advice

********** Research Office New Spring House 231 Glossop Road Sheffield S10 2GW

URMS Helpline: 21450 http://www.sheffield.ac.uk/researchoffice/

Appendix iii

a) Recruitment letter

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

June 2010

Pastoral care and supporting people with their mental health.

Dear Church Leader

I am a Trainee Clinical Psychologist conducting research on spiritual needs and mental health care. I am doing a study specifically focusing on the **experiences of those providing pastoral care** in supporting people in their community with their mental health. This may include ordained clergy, lay leaders or people with designated pastoral responsibilities. The results of this research will be written up as part of a doctoral (DClinPsy) thesis and may also be used for reports and publications.

There are two parts to this study:

- An interview (I will send you more information about this only if you indicate interest).
- A survey (which you can complete online now).

You can choose whether you would like to take part in either, neither or both of these.

(1) First, I would be grateful if you could take a moment to answer some brief screening questions. This should take less than 1 minute of your time. You can access these questions by clicking on this link: (SURVEYMONKEY LINK).

There will be a space for you to provide your contact details if you think you might be interested in taking part in an interview. If so, I will then send you further information about this to help you decide whether you wish to take part.

(2) Next, you will be connected to an online survey. You can complete this even if you do not want to take part in an interview. This should take up to 10 minutes of your time.

Please pass this information on to anyone else you know in a pastoral or church leadership role who may be interested.

If you do not have access to the internet but still wish to take part, you can leave a message for me with the Research Support Officer on 0114 2226650 and I will contact you.

If you have any questions about this study you can contact me by email on pcp08sw@shef.ac.uk or in writing at the address above.

Thank you for taking the time to read this.

With best wishes,

Sarah Wonders
Trainee Clinical Psychologist

Appendix iii

b) Screening questions

Pastoral care and supporting people with mental health difficulties.

Thank you for taking an interest in this study.

The following questions are part of a research project which has received ethical approval from the University of Sheffield. The research forms part of a doctoral (DClinPsy) thesis. Completion of this information is entirely voluntary. If you do not want to answer the questions below, you do not have to. If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Any returned information may be collated and reported in future publications. By submitting this you are consenting for the information you provide to be used in this way. Any information which identifies you will not be used. Data will be stored securely at the University of Sheffield in compliance with the Data Protection Act.

1) Do you regard yourself as a Christian leader or provider of pastoral care within a Christian community? **YES/NO**

2) Do you also work as a hospital chaplain? **YES/NO**

3) Are you aware of any people in your church community with mental health problems? **YES/NO**

4) Have you been involved with supporting individuals in your church community who have difficulties with their mental health? **YES/NO**

5) How much experience have you had **interacting with health services** (e.g. GP's, mental health teams, social workers, mental health nurses, care coordinators, counsellors, psychologists, psychiatrists) in supporting those with mental health problems in your faith community?

NONE **A LITTLE** **A MODERATE AMOUNT** **A LOT**

6) Would you consider participating in a research interview? **YES/NO**

If YES to question 6: Please complete your contact details below so that I can contact you at a later date. These details will be stored confidentially and will **only** be used to contact you. They will not be passed on to any third parties. You will be provided with further information before deciding whether you want to take part.

Name
Address
Email
Phone Number

Thank you.

[Click to submit]

We would now like to invite you to complete a short survey about mental health, your church community and your pastoral role. This should take no longer than 10 minutes of your time. Your answers will remain anonymous.

[Yes please, go to survey] **[No thanks, I do not want to complete the survey]**

Appendix iii

c) Online survey

Pastoral care and supporting people with their mental health[1]

We would like to find out about the experiences of those providing pastoral care within Christian church communities. The following survey asks you some questions about you and your role, your church, your views about mental health, working with health and social care services and support and training. It should take no longer than 10 minutes of your time. The survey is part of a research project which contributes to a doctoral (DClinPsy) thesis. It has received ethical approval from the University of Sheffield. Completion of the survey is voluntary. If you do not want to answer the questions below, you do not have to. You can exit the survey at any time by closing this internet window. The survey is anonymous, therefore once you have submitted your answers, it will not be possible to withdraw your data from the study. All data will be transmitted and stored securely and will be kept at the University of Sheffield. Data will only be accessed by those involved in the research and will be destroyed 5 years after the completion of the study.

Any returned information may be collated and reported (anonymously) in future publications. By submitting your answers you are consenting for the information you provide to be used in this way.

If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Thank you for your time

I have read and understand the information above [Y/N]
I understand that my participation is voluntary and that I do not have to complete the survey if I do not want to [Y/N]
I give consent to take part in this survey [Y/N]

About you.....

1. **Gender** [M/F]
2. **Age** [18-25, 26-35, 36-45, 46-55, 56-65, 66-75, 76+]
3. **First part of your church postcode only (e.g. S2, S17, NG5)** [Open text box – limit to 4 characters if possible]
4. **Would you regard your church as:** [Urban, Suburban, Rural]
5. **Church denomination** [Anglican, Methodist, Catholic, Baptist, Pentecostal, United Reformed, Salvation Army, Independent, Other (please state)]
6. **What is the estimated size of your church community (based on average weekly attendance)?** [Less than 50, 50-199, 200-499, 500-1000, More than 1000]
7. **How would you describe your current role in relation to the pastoral care you provide (e.g. youth worker, pastoral advisor, church leader)** [Open question]
8. **How many years of experience do you have overall in pastoral care role(s)** [0-5, 6-15, 16-25, 26-35, 35+]

[1] Please note this questionnaire was formatted appropriately when created on surveymonkey. This is an example of the content of the survey with response categories provided in brackets.

9. **Do you have additional qualifications in any of the following**: [Nursing, Counselling, Social Work, Medicine, Psychology, Other Health Profession?]
10. **Have you ever experienced mental health difficulties of your own?** [Y/N/prefer not to answer]
11. **Have your own experiences of mental health difficulties helped you in the care you provide to those in your community?**
    [N/A,They are irrelevant/unhelpful, Helpful if kept to myself, Helpful if shared with others]

We would be grateful if you could answer the following questions in relation to your role over the **past 5 years**.

<u>About your church and supporting people with their mental health....</u>

12. **Are you aware of any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
13. **Have you been involved in supporting any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
14. **How often do you discuss mental health issues with those in your pastoral care?**
[Never, very occasionally, occasionally, often, always]
15. **In the past 5 years, how many times have you been involved in *supporting* someone in your community with their mental health?**
    [Never, 1-5, 6-10, 11-15, 16-20, more than 20 times]
16. **What does the support you offer involve? [Open question]**
17. **In your role, are there activities that you are involved with that promote peoples' mental health and wellbeing?**
    [Yes (please specify-text box)/No]
18. **Does your church actively provide services (e.g. groups, courses) which specifically have a role in promoting or maintaining peoples' mental health?**
    [Yes (please specify-text box), No]

<u>Your views about mental health and wellbeing.....</u>

Please indicate your agreement with the following statements:

19. **Mental health is a topic which is relevant for the church**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
20. **I feel I have a good understanding of these issues**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
21. **I am confident in my ability to *notice* if somebody is experiencing difficulties in this area**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
22. **I am confident in supporting somebody with their mental health**

[Strongly agree – agree – unsure - disagree – strongly disagree]

23. **It is not part of my role to help support people with their mental health**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
24. **I usually know when somebody needs more help than I am able to offer (e.g. needs help from health services)**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
25. **It is difficult to distinguish between spiritual difficulties and mental health difficulties**
    [Strongly agree – agree – unsure - disagree – strongly disagree]

<u>Working with health and social care services.....</u>

26. **In the past 5 years, how often have you referred someone in your care to a health professional?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If never, please go to question [number])
27. **Who have you referred people to? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, MH chaplain, Counsellor, Other (please specify)]
28. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
29. **In the past 5 years, how often have you contacted a health professional for joint-working or advice?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If 'never' please go to Question [number])
30. **Who have you contacted? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor, Other (please specify)]
31. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
32. **Why did you make the referral or seek consultation?**
    [Open Q – text box]
33. **If you have never or rarely made a referral or sought consultation, what are the reasons for this?**
    [Not necessary, didn't think of it, didn't know how to refer, worried that health professionals won't understand person's faith, *patient did not want me to, it was not my responsibility, don't know when this is necessary, other (PLEASE SPECIFY)]*
34. **In what circumstances do you think that it would it be helpful to refer to a mental health professional? (Please select all which apply)**
    [Only if requested by person, when person is risk to self/others, person experiencing irrational thoughts/fears, when family/friends worried, when person thinks they are possessed, when experiencing religious delusions, other (please specify)]
35. **Do you know who your local chaplain is*? [Y/N]***
36. **In the past 5 years, has a health professional ever referred someone to you, or consulted you for advice in relation to a patient?**

[Never, once, 2-4 times, 5-7 times, 8 times or more]

37. **What was the profession of the person who contacted you? (Please select all that apply)**
    [N/A, GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor (NHS), Counsellor (Private), Counsellor (Religious), Other (PLEASE SPECIFY)]
38. **Generally, has your experience of working with health professionals been *helpful* in supporting member(s) of your community?**
    [Very much, mostly, a little bit, not at all]
39. **How would you rate the *communication* which you have received from the health professionals?**
    [Very poor, poor, adequate, good, very good]
40. **Generally, how much did you feel you had a shared understanding with the health professionals of the person's difficulties**
    [Very much, mostly, a little bit, not at all]
41. **How much did you feel you agreed about the best way to support the person and help manage their difficulties?**
    [Very much, mostly, a little bit, not at all]
42. **Did you receive any feedback from the health service staff, keeping you informed of the situation or of their actions?**
    [yes/no]
43. **Were there opportunites to work with or alongside the health professional(s) to support the person**
    [yes/no]
44. **How much did you feel that your role and opinion was valued by the health professional?**
    [Very much, mostly, a little bit, not at all]
45. **How much did you feel that your role and opinion was valued by the person in your community?**
    [Very much, mostly, a little bit, not at all]

<u>About support for you.....</u>

46. **Did you receive any training in mental health before qualifying/starting in your role?**
    [None, very little, adequate, a lot]
47. **Have you received any training in mental health since qualifying/starting in your role?**
    [None, very little, adequate, a lot]
48. **Do you feel that you and your wider church community are able to support those with mental health difficulties?**
    [Always, most of the time, sometimes, rarely, never]
49. **What kind of training or information about mental health care would you find most helpful now?**
    [None needed, promoting mental health/prevention of difficulties, warning signs/detection of difficulties, information about mental health difficulties and how to manage them , how to discern between mental and spiritual ill health, referral routes/confidentiality/data protection, knowing when to refer, other (PLEASE SPECIFY)]

Additional comments.....

Finally, is there anything else you would like to say? Are there any areas that you think have been overlooked? Is there anything else that you think it is important for researchers to consider?

[OPEN RESPONSE]

[FINISH AND SUBMIT MY ANSWERS!]

Thank you for taking the time to complete this survey.

If you have any questions regarding this study, please contact the researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Appendix iii

d) Information sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

INFORMATION SHEET

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take some time to decide whether or not you would like to take part. You can discuss this with others if you wish. Please ask if there is anything that is unclear or if you would like more information.

What is the purpose of the project?
We know that many people experience mental health difficulties at some point in their life. During times of distress people often turn to people they trust for help and support. They may also seek help from health services. Recent government guidelines recommend that effective links should be made between faith groups and health services.

This study aims to explore community-based Christian leaders'[2] *experiences* of providing pastoral support to members of their community with mental health needs. We do not know very much about this yet and would like to learn more. This research project forms part of a Doctoral DClinPsy thesis due for submission in July 2011.

Why have I been chosen?
You have indicated that you have some experience supporting people in your community with their mental health, and interacting with health care services. We are interested in hearing about your experiences. You have been selected from local Christian leaders who have experience in these areas and expressed an interest in participating in research.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You can still

[2] This includes ordained clergy, lay leaders and those with designated responsibilities in pastoral care roles.

withdraw from the research at any time before, during or up to 2 weeks after the interview. You do not have to give a reason.

What will happen to me if I take part?
If you decide to take part, you will be visited by a researcher at a location which is convenient to you. The interview will need to take place in a quiet/confidential environment. If this is not possible at your place of work or residence, arrangements may be made to conduct the interviews at the university site.
You will go through this information sheet with the researcher and be given the opportunity to ask questions. If you are still happy to take part, you will be asked to sign a consent form.
You will then be interviewed by the researcher. This will be a series of open questions (rather than a structured questionnaire) and will require you to speak openly about your experiences. Length of individual interviews will vary, but we estimate that the interview will last around 1 hour. Interviews will be recorded using audio equipment.
You will also be asked for some background information about yourself and your church (such as age, ethnicity, training/occupational background, church denomination/affiliation, size of congregation).

What do I have to do?
You will be asked to be present at an agreed time and place to take part in the interview with the researcher. You will need to be available for the full length of the interview. You will also need to allow some time to go through this information sheet and complete the background data.

Will my taking part in this project be kept confidential?
All the information that we collect about you during the course of the research will be confidential and will be stored securely at the University of Sheffield in accordance with the Data Protection Act. Data will be kept for 5 years following completion of the study and then destroyed.

Only those directly involved in the research, and University approved transcribers will have access to this. Transcribers sign a statement of confidentiality before beginning transcription and are required to discontinue transcription if the person involved in the interview is known to them.

Extracts from the interview may be used in reports and publications, however, every effort will be made to ensure you are not identifiable in these. Names (e.g. of individuals or churches) will not be used, or will be replaced with pseudonyms.

However, in the event that anything you say leads us to be concerned about your own safety, or the safety of others, we have a duty to act on this. Similarly we cannot maintain confidentiality if we are required to pass on information for legal reasons.

What are the possible disadvantages and risks of taking part?
Although we do not anticipate any undue risks for those taking part there are some things to consider.

The interview will take up some of your time. Neither the researcher nor yourself can predict the exact details of the discussion during the interview. There is a chance that you may think back over what you talked about and not be comfortable with this. If this is the case you can contact the researcher up to 2 weeks after the interview and ask to withdraw from the study. In the unlikely event that the interview causes you any distress, you can ask to stop the interview. We would advise you to seek support from your colleagues or visit your GP.

During the interview it is likely that you will talk about your experiences working with other people. We would ask you to consider your own codes of confidentiality whilst doing this and avoid mentioning names or identifiable information. As mentioned above, if any names *are* mentioned during the interview, these will not be used, or will be replaced with pseudonyms.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for individuals participating in the project, it is hoped that this work will help us to understand the experiences of those in pastoral care roles who support people with their mental health, and have experience working with health services. We hope that this will help inform future practice in finding approaches which support peoples' spiritual and mental health needs.

What happens if the research study stops earlier than expected?
If this is the case the reason(s) should be explained to you.

Will I be recorded, and how will the recorded media be used?
The interviews will be recorded using audio tape. The audio recordings of the research interview will be transcribed into written form and used for analysis. No other use will be made of them without your written permission, and no one outside of the project will be allowed access to the original recordings.

The tapes will be stored confidentially at the University of Sheffield for as long as required. They will be disposed of after the research has been completed and they are no longer required for auditing purposes.

What will happen to the results of the research project?
The results of the overall project will be written up and submitted as a DClinPsy research thesis. Results may also be published as reports or journal articles. As mentioned above, identifiable information will not be used in any reports/publications. A copy of any publications can be obtained upon request from the researcher.

Who is organising and funding the research?
This research is funded by the NHS and the Clinical Psychology Unit at the University of Sheffield.

Expenses and payments.
We regret that we do not have sufficient funding to compensate you for any expenses incurred in participating (e.g. travel or compensation for your time) and your participation would be entirely voluntary.

Who has ethically reviewed the project?
This project has received ethical approval by the Department of Psychology's Ethics Review Committee at the University of Sheffield.

What if I want to make a complaint?
Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

Telephone: 0114 2226637

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Contact for further information
For information relating to this study please contact the primary researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Telephone messages can be left with the Research Support Officer on: 0114 2226650.
Please note: the Research Support Officer cannot answer enquiries about the project but can pass on a message to Sarah Wonders (the researcher) who will call you back.

Thank you for taking the time to read this.

Appendix iii

e) Consent form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

CONSENT FORM

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

Name of Researcher: Sarah Wonders

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated ……. for the above project and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw before, during, or up to 2 weeks after the interview without giving any reason. ☐

   (Should you choose to withdraw, you can do this by writing to Sarah Wonders at Clinical Psychology Unit, Department of Psychology, Western Bank, Sheffield, S10 2TN. Or by email pcp08sw@shef.ac.uk)

3. I understand that the interview will be recorded using audio equipment. I give permission for the interview to be recorded in this way. ☐

4. I understand that an approved transcriber who has signed a confidentiality agreement will also listen to the tapes to type them into written form. ☐

5. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my responses. ☐

6. I understand that the results of the research project may be published, and that this may include anonymised quotes from my interview. ☐

7. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

(*if different from lead researcher*) *To be signed and dated in presence of the participant*

_____	_____	_____
Lead Researcher	Date	Signature

To be signed and dated in presence of the participant

Thank you for agreeing to take part.

Appendix iii

f) Topic guide

[Introduce self and study, info sheets and consent]

1) **To begin with, I wonder if you could tell me a little bit about your role in pastoral care of your church community?**

    - What do you view as your role?
    - How would you define this role?
    - Can you give me some examples of the things you do?
        - Is there anything else you do which you have not mentioned?
    - What do you view as outside of your role?
    - How do you think other people view your role?
    - How much of your time/day/week does it take up?

2) **Can you talk a bit about your experiences supporting people with their mental health?**

    - In your role, what sorts of words do you use when talking about peoples' mental health? Are there any words or phrases that you would avoid?
    - What would be your understanding of mental health?
    - Without breaking confidentiality, or naming any individuals, can you think of an example of someone who has experienced problems with their mental health?
        - Tell me a bit about what happened with that person?
        - How did you become aware of their difficulties?
        - Describe your interactions with each other?
        - What was your understanding of the issues they were facing?
    - Have you had any other experiences before/since then?
        - How was this different? How was it similar?
    - How often do you encounter people with mental health difficulties?
        - Why do you think this is the case?
    - How do you think your church community interacts with/experiences those with mental health difficulties?

- How do those with mental health problems interact with/experience the church community?

- What are the main issues which arise when supporting people with people with their mental health?
- Are there other things which you or your church do to support people with their mental health?

3) **Could you tell me about your experiences working alongside or interacting with health professionals or health services in relation to the mental health of those in your community?**

- Can you think of a time when you have had contact with health services/professionals?
  - How did this come about?
  - What happened?
  - Who contacted who?
  - How did you feel about it?
- Was anything helpful about this? Was anything unhelpful/difficult?
- What was communication like? Did you have any similar or different points of view?

4) **Tell me about the outcome or impact of this work?**

- Did your experience have an effect on you in anyway?
  - How do you think the experience affected the person you were supporting?
  - Did you notice any impact for the health professionals?
- How did you feel about it at the time? How do you feel about it now?
- Have you learned anything from your experiences?
- Would you hope anything to be similar or different in the future?
- Is there anything you would find helpful in supporting those with mental health needs? Is there anything that you would find unhelpful?

Well, that's the end of the questions from me, but before we finish, I wondered if there's anything you wish I'd asked you more about? Is there anything you think I should have asked you that I haven't? Is there anything else you would like to say?

[Complete demographic sheet]
[Debrief. Ascertain interest in findings. Inform of likely timings and contact details.]

Appendix iii

g) Demographics sheet

Participant Demographics

Gender: Male / Female

Age:

Ethnicity:

Ordained/Lay Leader?

Years of experience in Church Ministry:

Chaplaincy experience?

Occupational history:

Highest Educational Qualification:

Personal Denomination/Church Affiliation:

Additional info of note:

Church Demographics

Size (average weekly attendance):

Catchment: Rural Urban Suburban

Demographic of congregation (age, ethnicity, SES):

Denomination/Affiliation:

How would you describe your church:

Additional info of note:

Appendix iii

h) **Extracts from analysis**

1. **Extract from coded transcript**

Theme	Text	Initial notes/coding
"Managed availability" Maintaining health of clergy and clients Christ as role model	Erm, and, but even that's a managed availability in a sense. I think it's also very destructive for the priest because it tends to, it tends to feed in to our sort of, well, counter-transference I suppose if one wants to use that sort of language, of...actually..it often tends to be an identification with, self-identification with Christ in an unhealthy way that I *ought* to be all loving, always available, always for people and therefore I can't draw any boundaries because Jesus didn't. Of course that's false because he did (small laugh), er, in fact, erm, and it's very interesting to read the Gospels with the view to exploring the question of availability, unavailability and boundary for Christ because actually there's a surprising amount in it, erm, but it, it doesn't help the client and it doesn't, it doesn't assist the priest. **R:** So..	Importance of sustaining health for client and clergy 'Meeting' me in my professional role? Christ as a role model Refer to scripture for guidance/wisdom NB. Part of his role is pastoral care of his colleagues so is this why there is a big focus on protecting professional boundaries??

Clergy-led/in charge Importance of multiple boundaries: Time, frequency, space Significance of boundaries Clergy make offering to person based on perceived need (adapting to need)	**P:** and so, yeah, I could say there's, if we look at it there's b- boundaries of time that, I make a certain amount of time available and then I will pace when I'm available in the future. I much prefer offering pastoral care, if I'm seeing somebody more than twice I would typically be seeing them once every, except during a moment of crisis, I'd be seeing them every four or six weeks so it's really quite occasional. Erm..I'd, I'd set a boundary of time and how long I would see people..I would set a boundary of space in as much as I'd almost always meet in a, erm, safe space where other people were around or in a quiet place where I'm almost observed in the cathedral and you see that [knocks] even the table here is carefully designed to, to, to keep boundaries and because there's such, has been such poor practice in boundaries of space and touching..people, erm, I..*never*..touch somebody. Erm..I very occasionally when somebody's extremely distressed I'll offer an open, a palm..an open hand..and then it's for the person to decide whether	Time management "I" = Maintaining control. Specified. Led by own model of practice. LOTS of attention and time given to emphasising boundaries! Important. Avoid isolation? Vulnerability/fear? Recognition of historical issues in church influencing current practice

Choice remains with client	they wish to hold my hand but they're holding it, and often with people who are dying or who are in enormous pain, offering a hand like that and just remaining silent with a person is the most effective engagement but even with somebody who's dying in, it's always, it's almost always possible for them to decide..to initiate touch	Individual autonomy Offering Simplicity in approach Client-led

Appendix iii

h) Extracts from analysis

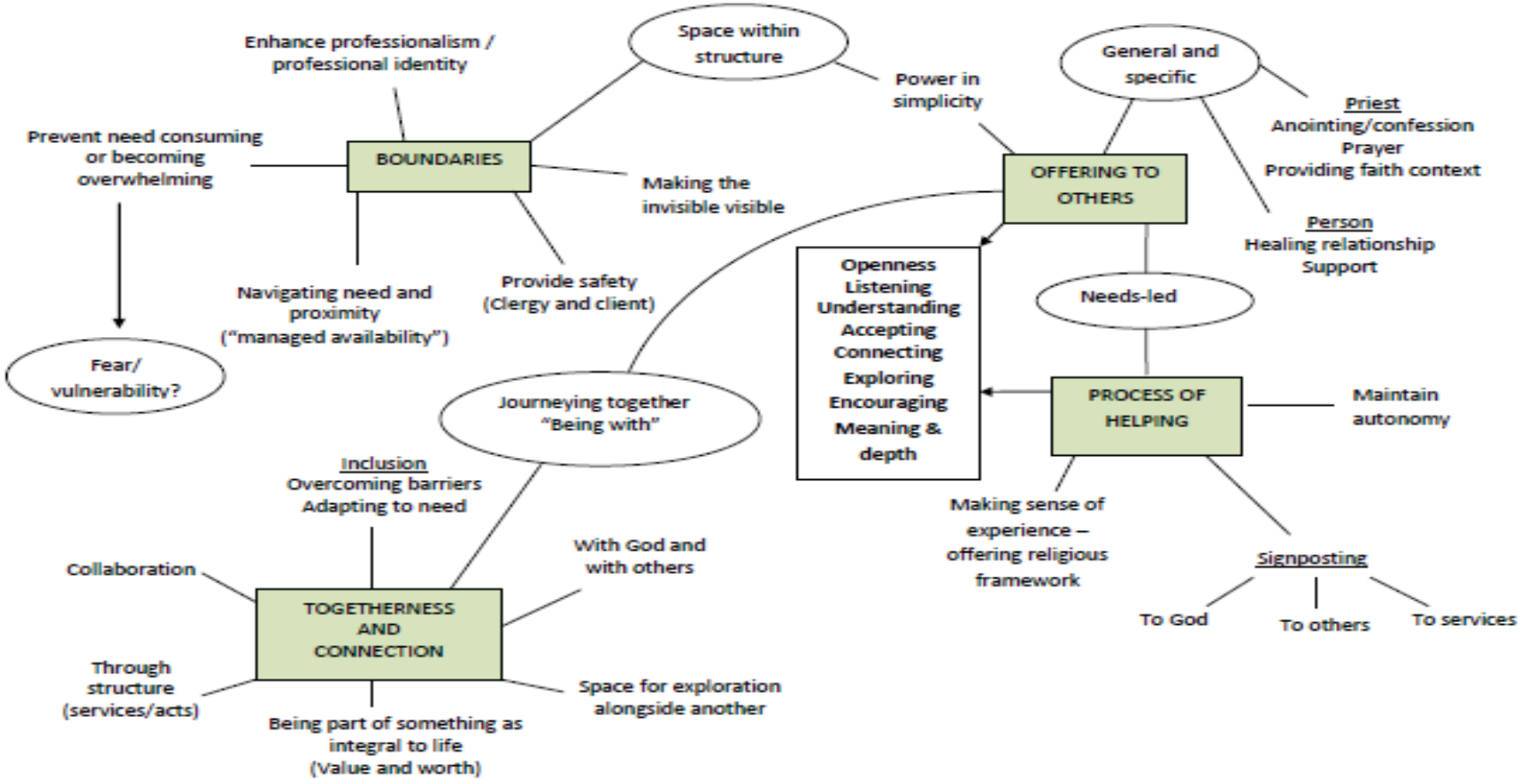
2. Extract of list of themes

Theme	Page	Line ref
Role located within hierarchy	1	4-16
Seniority and uniqueness		6, 12,
From parliament/policy to people		11-14
Pastoral role at multiple levels of system		6-14
Extensiveness of role, held within structure	2	16-19
Giving of self, receiving of others "witness"		24-28
OFFERING - safety, thought, hearing, meaning		26-28
Opportunity for exploration/meaning		27-28
Importance of clear understanding	3	37
Depth of interaction - seeing and hearing beyond the immediate		37-38
Strong, clear structure and boundaries in place (imposed?) around *collaborative* exploration		40-45
Moving forward as part of process	4	47
People seek out clergy		49
"Formula"/structure allows clergy to maintain control of interaction		50-56
Boundaries infused through interactions		53-56
Listening as a process of picking apart("tease out"), checking understanding and bringing together ("summarising")		58-61

Appendix iii

h) Extracts from analysis

3. Exemplar map


Space within structure
Enhance professionalism / professional identity
Power in simplicity
General and specific
Priest
Anointing/confession
Prayer
Providing faith context
Prevent need consuming or becoming overwhelming
BOUNDARIES
Making the invisible visible
OFFERING TO OTHERS
Person
Healing relationship
Support
Navigating need and proximity ("managed availability")
Provide safety (Clergy and client)
Openness
Listening
Understanding
Accepting
Connecting
Exploring
Encouraging
Meaning & depth
Needs-led
Fear/ vulnerability?
Journeying together "Being with"
PROCESS OF HELPING
Maintain autonomy
Inclusion
Overcoming barriers
Adapting to need
Making sense of experience – offering religious framework
Signposting
Collaboration
With God and with others
TOGETHERNESS AND CONNECTION
To God
To others
To services
Through structure (services/acts)
Space for exploration alongside another
Being part of something as integral to life (Value and worth)

Appendix iii

i) **Ordination liturgy**

Extract from the Church of England liturgy for the ordination of priests. Retrieved from:
http://www.churchofengland.org/prayer-worship/worship/texts/ordinal/priests.aspx

The Declarations

Bishop: Priests are called to be servants and shepherds among the people to whom they are sent. With their Bishop and fellow ministers, they are to proclaim the word of the Lord and to watch for the signs of God's new creation. They are to be messengers, watchmen and stewards of the Lord; they are to teach and to admonish, to feed and provide for his family, to search for his children in the wilderness of this world's temptations, and to guide them through its confusions, that they may be saved through Christ for ever. Formed by the word, they are to call their hearers to repentance and to declare in Christ's name the absolution and forgiveness of their sins.

With all God's people, they are to tell the story of God's love. They are to baptize new disciples in the name of the Father, and of the Son, and of the Holy Spirit, and to walk with them in the way of Christ, nurturing them in the faith. They are to unfold the Scriptures, to preach the word in season and out of season, and to declare the mighty acts of God. They are to preside at the Lord's table and lead his people in worship, offering with them a spiritual sacrifice of praise and thanksgiving. They are to bless the people in God's name. They are to resist evil, support the weak, defend the poor, and intercede for all in need. They are to minister to the sick and prepare the dying for their death. Guided by the Spirit, they are to discern and foster the gifts of all God's people, that the whole Church may be built up in unity and faith.

The bishop addresses the ordinands

We trust that long ago you began to weigh and ponder all this, and that you are fully determined, by the grace of God, to devote yourself wholly to his service, so that as you daily follow the rule and teaching of our Lord and grow into his likeness, God may sanctify the lives of all with whom you have to do.

Appendix i

a) **Journal approval letter**

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

21st February 2011

Sarah Wonders
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Sarah

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Mental Health, Religion and Culture

Research Report: Mental Health, Religion and Culture

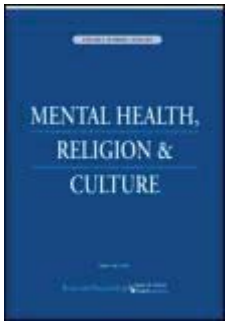
Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Dr Rebecca Knowles
Research Tutor

Appendix i

b) Notes for authors



Mental Health, Religion & Culture

Published By: Routledge
Volume Number: 14

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Instructions for Authors

SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

The instructions below are specifically directed at authors that wish to submit a manuscript to ***Mental Health, Religion & Culture***. For general information, please visit the Publish With Us section of our website.

Mental Health, Religion & Culture **considers all manuscripts on the strict condition that they have been submitted only to** ***Mental Health, Religion & Culture*****, that they have not been published already, nor are they under consideration for publication or in press elsewhere. Authors who fail to adhere to this condition will be charged with all costs which** ***Mental Health, Religion & Culture*** **incurs and their papers will not be published.**

Contributions to ***Mental Health, Religion & Culture*** **must report original research and will be subjected to anonymous review by independent referees at the discretion of the Editorial Office.**

Manuscript submission

Manuscripts for consideration should be submitted via the ***Mental Health, Religion & Culture*** ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site, submissions should be made via the Author Centre. Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to reviewers. When uploading files authors will then be able to define the non-anonymous version as "File not for review."

Papers that specifically concern **psychiatry, anthropology, medicine and sociology** should be directed to Dr Simon Dein.

Papers that specifically concern **psychology and religious studies** should be directed either to Professor Kate Miriam Loewenthal, or Dr Christopher Alan Lewis. If in doubt, papers can be directed to any Editor.

Authors are invited to nominate up to two referees (not from their own institution) although it is not guaranteed that they will be consulted.

Books for review

Books for review should be directed to Dr Christopher Alan Lewis via the online ***Mental Health, Religion & Culture*** Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

For queries regarding book reviews, please contact Dr C.A. Lewis at: School of Psychology, University of Ulster at Magee College, Northland Road, Londonderry BT48 7JL, Northern Ireland (tel: +44(0)2871 375301; fax +44(0)2871 375402)

Manuscript preparation:

1. General guidelines

- Papers are accepted English. British English spelling and punctuation is preferred.
- A typical article may be between **5,000** and **10,000 words**. A short article for rapid publication will not exceed **2,000 words**. Papers that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendices (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- An abstract of no more than 150 words is required for all papers submitted.
- Each paper should have between three and seven keywords.
- The title page should include the title of the paper, all the authors' full names, affiliations, postal addresses, telephone and fax numbers and email addresses. One author should be identified as the Corresponding Author at the bottom of the page. An abbreviated title should also be given, for running headlines within the article.
- Biographical notes on contributors are not required for this journal.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal's article style, Quick guide
- Description of the Journal's reference style, Quick guide
- Manuscripts may be submitted in any standard format, including Word, PostScript and PDF. These files will be automatically converted into a PDF file for the review process.
- This journal does not accept Microsoft Word 2007 documents.
- Please use British spelling (e.g. colour, organise). Use double quotation marks with single within if needed.

If you have any questions about references or formatting your article, please contact authorqueries@tandf.co.uk (please mention the journal title in your email).

Word templates
Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk

3. Figures

We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each figure should be numbered with Figure number (Arabic numerals).
- Figures must be saved separate to text. Please do not embed figures in the main document.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the paper (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly. Captions should include keys to symbols, and should make interpretation possible without reference to the text.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Please note that it is in the author's interest to provide the highest quality figure format possible. Please do not hesitate to contact our Production Department if you have any queries.

4. Tables

Tables should be numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

5. Reproduction of copyright material

As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). For further information and FAQs, please see http://journalauthors.tandf.co.uk/preparation/permission.asp. This applies to direct reproduction as well as 'derivative reproduction', where the contributor has created a new figure or table that derives substantially from a copyrighted source. Authors are themselves responsible for the payment of any permission fees required by the copyright owner. Copies of permission letters should be sent with the manuscript upon submission to the Editor(s).

- **Copyright permission letter template**

6. Informed consent

Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

7. Code of experimental ethics and practice and confidentiality

Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the Editor if they wish.

8. Conflict of Interests

All authors of accepted articles will be required to complete a declaration of competing interests and/or financial support.

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Advice to authors on preparing a manuscript

NB: Please follow any specific instructions for authors provided by the Editor of the journal

Font: Times New Roman, 12 point. Use margins of at least 2.5 cm (1 inch).

Title: Use bold for your article title, with an initial capital letter for any proper nouns.

Authors' names: Give the names of all contributing authors on the title page exactly as you wish them to appear in the published article.

Affiliations: List the affiliation of each author (department, university, city, and country).

Correspondence details: Please provide an institutional email address for the corresponding author. Full postal details are also needed by the publisher, but will not necessarily be published.

Anonymity for peer review: Ensure your identity and that of your co-authors is not revealed in the text of your article or in your manuscript files when submitting the manuscript for review. Advice on anonymizing your manuscript is available here.

Abstract: Indicate the abstract paragraph with a heading or by reducing the font size. Advice on writing abstracts is available here.

Keywords: Please provide five or six keywords to help readers find your article. Advice on selecting suitable keywords is available here.

Headings: Please indicate the level of the section headings in your article:

- First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.
- Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.
- Third-level headings should be in italics, with an initial capital letter for any proper nouns.
- Fourth-level headings should also be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. The actual tables and figures should be supplied either at the end of the text or in a separate file as requested by the Editor. Ensure you have permission to use any figures you are reproducing from another source. Advice on artwork is available here.

Running heads and **received dates** are not required when submitting a manuscript for review.

If your article is accepted for publication, it will be copy-edited and typeset in the correct style for the journal.

If you have any queries, please contact us at authorqueries@tandf.co.uk, mentioning the full title of the journal you are interested in, or see our Author Services homepage.

Appendix ii

a) **Ethical approval**

------ Forwarded Message

Date: Thu, 24 Jun 2010 09:51:26 +0100

To: <G.Rowse@sheffield.ac.uk>

Subject: Approval of your research proposal

Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals. " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,

Prof Paschal Sheeran

Chair, DESC

------ End of Forwarded Message

Appendix ii

b) Governance approval

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

6th June 2010

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals
Investigators: Sarah Wonders (DClin Psy Trainee, University of Sheffield); Dr Georgina Rowse, Dr Andrew Thompson (Academic Supervisors, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it, and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

Dr. Rebecca Knowles
Research Tutor

Co. Sarah Wonders, Dr Georgina Rowse, Dr Andrew Thompson

-------- Original Message --------

Subject: Your project in URMS, 128956, has now been authorised

Date: 14 Jul 10 14:50:30

From: noreply@sheffield.ac.uk

To: C.Harrison@sheffield.ac.uk

Project code: 128956

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals (Sarah Wonders)

This project has now been checked and authorised by the Research Office. Relevant details can now be transferred to any application forms or documentation. Please note that you should use figures from a project report with the status COSTING APPROVED to ensure you have the finalised figures.

Please note that staff named as Principal Investigator or co-Investigator on the "Investigators" page of the URMS record can access the costing and can, therefore, necessarily see the salaries of staff costed on the grant. Staff salary information is only made available for the purpose of calculating the cost of an application, is strictly confidential and should not be discussed.

Should you have any queries relating to the costs, please contact the URMS helpline on 21450.

GUIDANCE ON URMS PROJECTS AT THE "COSTING APPROVED" STAGE

1. Research applications require Institutional authorisation before submission to the funder. Completed hardcopy applications should be either mailed or dropped off at the Research Office (via the "Research Applications" mailbox) together with any requisite supporting paperwork such as procurement forms or letters of support, and contact details for any queries.

Applications with a full economic cost value less than GBP 750,000 received before noon on any working day will be available for collection by noon the following working day. Applications received after noon will be available by 5pm the following working day. Applications can be returned to departments via mail if required.

Applications with a full economic cost value greater than GBP 750,000 require four days for authorisation due to the availability of the small number of authorised signatories above this amount.

Please note that these timescales also apply to electronic applications.

2. If the Department of Health's "Research Governance Framework" is applicable to the project and external or additional funding is not being sought, e.g. "own account" or student research projects, the project will not be moved to APPLICATION AUTHORISED until the Research Office has received written confirmation of which organisation is the project's Research Governance sponsor.

3. There are several web resources available to staff on the Research Office website, including:

Information regarding University processes for research costing, applications and contracts at: http://www.sheffield.ac.uk/researchoffice/overview/contract.html

Guidance on Research Governance, Clinical Trials & Ethics (and access to the Good Research Practice Standards) at: http://www.sheffield.ac.uk/researchoffice/gov_ethics_grp/governance

General advice and guidance regarding research applications at: http://www.sheffield.ac.uk/researchoffice/advice

********** Research Office New Spring House 231 Glossop Road Sheffield S10 2GW

URMS Helpline: 21450 http://www.sheffield.ac.uk/researchoffice/

Appendix iii

a) Recruitment letter

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

June 2010

Pastoral care and supporting people with their mental health.

Dear Church Leader

I am a Trainee Clinical Psychologist conducting research on spiritual needs and mental health care. I am doing a study specifically focusing on the **experiences of those providing pastoral care** in supporting people in their community with their mental health. This may include ordained clergy, lay leaders or people with designated pastoral responsibilities. The results of this research will be written up as part of a doctoral (DClinPsy) thesis and may also be used for reports and publications.

There are two parts to this study:

- An interview (I will send you more information about this only if you indicate interest).
- A survey (which you can complete online now).

You can choose whether you would like to take part in either, neither or both of these.

(1) First, I would be grateful if you could take a moment to answer some brief screening questions. This should take less than 1 minute of your time. You can access these questions by clicking on this link: (SURVEYMONKEY LINK).

There will be a space for you to provide your contact details if you think you might be interested in taking part in an interview. If so, I will then send you further information about this to help you decide whether you wish to take part.

(2) Next, you will be connected to an online survey. You can complete this even if you do not want to take part in an interview. This should take up to 10 minutes of your time.

Please pass this information on to anyone else you know in a pastoral or church leadership role who may be interested.

If you do not have access to the internet but still wish to take part, you can leave a message for me with the Research Support Officer on 0114 2226650 and I will contact you.

If you have any questions about this study you can contact me by email on pcp08sw@shef.ac.uk or in writing at the address above.

Thank you for taking the time to read this.

With best wishes,

Sarah Wonders
Trainee Clinical Psychologist

Appendix iii

b) Screening questions

Pastoral care and supporting people with mental health difficulties.

Thank you for taking an interest in this study.

The following questions are part of a research project which has received ethical approval from the University of Sheffield. The research forms part of a doctoral (DClinPsy) thesis. Completion of this information is entirely voluntary. If you do not want to answer the questions below, you do not have to. If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Any returned information may be collated and reported in future publications. By submitting this you are consenting for the information you provide to be used in this way. Any information which identifies you will not be used. Data will be stored securely at the University of Sheffield in compliance with the Data Protection Act.

1) Do you regard yourself as a Christian leader or provider of pastoral care within a Christian community? **YES/NO**

2) Do you also work as a hospital chaplain? **YES/NO**

3) Are you aware of any people in your church community with mental health problems? **YES/NO**

4) Have you been involved with supporting individuals in your church community who have difficulties with their mental health? **YES/NO**

5) How much experience have you had **interacting with health services** (e.g. GP's, mental health teams, social workers, mental health nurses, care coordinators, counsellors, psychologists, psychiatrists) in supporting those with mental health problems in your faith community?

NONE **A LITTLE** **A MODERATE AMOUNT** **A LOT**

6) Would you consider participating in a research interview? **YES/NO**

If YES to question 6: Please complete your contact details below so that I can contact you at a later date. These details will be stored confidentially and will **only** be used to contact you. They will not be passed on to any third parties. You will be provided with further information before deciding whether you want to take part.

Name
Address
Email
Phone Number

Thank you.

[Click to submit]

We would now like to invite you to complete a short survey about mental health, your church community and your pastoral role. This should take no longer than 10 minutes of your time. Your answers will remain anonymous.

[Yes please, go to survey] **[No thanks, I do not want to complete the survey]**

Appendix iii

c) Online survey

Pastoral care and supporting people with their mental health[1]

We would like to find out about the experiences of those providing pastoral care within Christian church communities. The following survey asks you some questions about you and your role, your church, your views about mental health, working with health and social care services and support and training. It should take no longer than 10 minutes of your time. The survey is part of a research project which contributes to a doctoral (DClinPsy) thesis. It has received ethical approval from the University of Sheffield. Completion of the survey is voluntary. If you do not want to answer the questions below, you do not have to. You can exit the survey at any time by closing this internet window. The survey is anonymous, therefore once you have submitted your answers, it will not be possible to withdraw your data from the study. All data will be transmitted and stored securely and will be kept at the University of Sheffield. Data will only be accessed by those involved in the research and will be destroyed 5 years after the completion of the study.

Any returned information may be collated and reported (anonymously) in future publications. By submitting your answers you are consenting for the information you provide to be used in this way.

If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Thank you for your time

I have read and understand the information above [Y/N]
I understand that my participation is voluntary and that I do not have to complete the survey if I do not want to [Y/N]
I give consent to take part in this survey [Y/N]

About you.....

1. **Gender** [M/F]
2. **Age** [18-25, 26-35, 36-45, 46-55, 56-65, 66-75, 76+]
3. **First part of your church postcode only (e.g. S2, S17, NG5)** [Open text box – limit to 4 characters if possible]
4. **Would you regard your church as:** [Urban, Suburban, Rural]
5. **Church denomination** [Anglican, Methodist, Catholic, Baptist, Pentecostal, United Reformed, Salvation Army, Independent, Other (please state)]
6. **What is the estimated size of your church community (based on average weekly attendance)?** [Less than 50, 50-199, 200-499, 500-1000, More than 1000]
7. **How would you describe your current role in relation to the pastoral care you provide (e.g. youth worker, pastoral advisor, church leader)** [Open question]
8. **How many years of experience do you have overall in pastoral care role(s)** [0-5, 6-15, 16-25, 26-35, 35+]

[1] Please note this questionnaire was formatted appropriately when created on surveymonkey. This is an example of the content of the survey with response categories provided in brackets.

9. **Do you have additional qualifications in any of the following**: [Nursing, Counselling, Social Work, Medicine, Psychology, Other Health Profession?]
10. **Have you ever experienced mental health difficulties of your own?** [Y/N/prefer not to answer]
11. **Have your own experiences of mental health difficulties helped you in the care you provide to those in your community?**
    [N/A,They are irrelevant/unhelpful, Helpful if kept to myself, Helpful if shared with others]

We would be grateful if you could answer the following questions in relation to your role over the **past 5 years**.

<u>About your church and supporting people with their mental health....</u>

12. **Are you aware of any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
13. **Have you been involved in supporting any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
14. **How often do you discuss mental health issues with those in your pastoral care?**
[Never, very occasionally, occasionally, often, always]
15. **In the past 5 years, how many times have you been involved in *supporting* someone in your community with their mental health?**
    [Never, 1-5, 6-10, 11-15, 16-20, more than 20 times]
16. **What does the support you offer involve? [Open question]**
17. **In your role, are there activities that you are involved with that promote peoples' mental health and wellbeing?**
    [Yes (please specify-text box)/No]
18. **Does your church actively provide services (e.g. groups, courses) which specifically have a role in promoting or maintaining peoples' mental health?**
    [Yes (please specify-text box), No]

<u>Your views about mental health and wellbeing.....</u>

Please indicate your agreement with the following statements:

19. **Mental health is a topic which is relevant for the church**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
20. **I feel I have a good understanding of these issues**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
21. **I am confident in my ability to *notice* if somebody is experiencing difficulties in this area**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
22. **I am confident in supporting somebody with their mental health**

[Strongly agree – agree – unsure - disagree – strongly disagree]

23. **It is not part of my role to help support people with their mental health**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
24. **I usually know when somebody needs more help than I am able to offer (e.g. needs help from health services)**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
25. **It is difficult to distinguish between spiritual difficulties and mental health difficulties**
    [Strongly agree – agree – unsure - disagree – strongly disagree]

<u>Working with health and social care services.....</u>

26. **In the past 5 years, how often have you referred someone in your care to a health professional?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If never, please go to question [number])
27. **Who have you referred people to? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, MH chaplain, Counsellor, Other (please specify)]
28. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
29. **In the past 5 years, how often have you contacted a health professional for joint-working or advice?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If 'never' please go to Question [number])
30. **Who have you contacted? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor, Other (please specify)]
31. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
32. **Why did you make the referral or seek consultation?**
    [Open Q – text box]
33. **If you have never or rarely made a referral or sought consultation, what are the reasons for this?**
    [Not necessary, didn't think of it, didn't know how to refer, worried that health professionals won't understand person's faith, *patient did not want me to, it was not my responsibility, don't know when this is necessary, other (PLEASE SPECIFY)]*
34. **In what circumstances do you think that it would it be helpful to refer to a mental health professional? (Please select all which apply)**
    [Only if requested by person, when person is risk to self/others, person experiencing irrational thoughts/fears, when family/friends worried, when person thinks they are possessed, when experiencing religious delusions, other (please specify)]
35. **Do you know who your local chaplain is*? [Y/N]***
36. **In the past 5 years, has a health professional ever referred someone to you, or consulted you for advice in relation to a patient?**

[Never, once, 2-4 times, 5-7 times, 8 times or more]

37. **What was the profession of the person who contacted you? (Please select all that apply)**
    [N/A, GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor (NHS), Counsellor (Private), Counsellor (Religious), Other (PLEASE SPECIFY)]
38. **Generally, has your experience of working with health professionals been *helpful* in supporting member(s) of your community?**
    [Very much, mostly, a little bit, not at all]
39. **How would you rate the *communication* which you have received from the health professionals?**
    [Very poor, poor, adequate, good, very good]
40. **Generally, how much did you feel you had a shared understanding with the health professionals of the person's difficulties**
    [Very much, mostly, a little bit, not at all]
41. **How much did you feel you agreed about the best way to support the person and help manage their difficulties?**
    [Very much, mostly, a little bit, not at all]
42. **Did you receive any feedback from the health service staff, keeping you informed of the situation or of their actions?**
    [yes/no]
43. **Were there opportunites to work with or alongside the health professional(s) to support the person**
    [yes/no]
44. **How much did you feel that your role and opinion was valued by the health professional?**
    [Very much, mostly, a little bit, not at all]
45. **How much did you feel that your role and opinion was valued by the person in your community?**
    [Very much, mostly, a little bit, not at all]

<u>About support for you.....</u>

46. **Did you receive any training in mental health before qualifying/starting in your role?**
    [None, very little, adequate, a lot]
47. **Have you received any training in mental health since qualifying/starting in your role?**
    [None, very little, adequate, a lot]
48. **Do you feel that you and your wider church community are able to support those with mental health difficulties?**
    [Always, most of the time, sometimes, rarely, never]
49. **What kind of training or information about mental health care would you find most helpful now?**
    [None needed, promoting mental health/prevention of difficulties, warning signs/detection of difficulties, information about mental health difficulties and how to manage them , how to discern between mental and spiritual ill health, referral routes/confidentiality/data protection, knowing when to refer, other (PLEASE SPECIFY)]

Additional comments.....

Finally, is there anything else you would like to say? Are there any areas that you think have been overlooked? Is there anything else that you think it is important for researchers to consider?

[OPEN RESPONSE]

[FINISH AND SUBMIT MY ANSWERS!]

Thank you for taking the time to complete this survey.

If you have any questions regarding this study, please contact the researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Appendix iii

d) Information sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

INFORMATION SHEET

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take some time to decide whether or not you would like to take part. You can discuss this with others if you wish. Please ask if there is anything that is unclear or if you would like more information.

What is the purpose of the project?
We know that many people experience mental health difficulties at some point in their life. During times of distress people often turn to people they trust for help and support. They may also seek help from health services. Recent government guidelines recommend that effective links should be made between faith groups and health services.

This study aims to explore community-based Christian leaders'[2] *experiences* of providing pastoral support to members of their community with mental health needs. We do not know very much about this yet and would like to learn more. This research project forms part of a Doctoral DClinPsy thesis due for submission in July 2011.

Why have I been chosen?
You have indicated that you have some experience supporting people in your community with their mental health, and interacting with health care services. We are interested in hearing about your experiences. You have been selected from local Christian leaders who have experience in these areas and expressed an interest in participating in research.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You can still

[2] This includes ordained clergy, lay leaders and those with designated responsibilities in pastoral care roles.

withdraw from the research at any time before, during or up to 2 weeks after the interview. You do not have to give a reason.

What will happen to me if I take part?
If you decide to take part, you will be visited by a researcher at a location which is convenient to you. The interview will need to take place in a quiet/confidential environment. If this is not possible at your place of work or residence, arrangements may be made to conduct the interviews at the university site.
You will go through this information sheet with the researcher and be given the opportunity to ask questions. If you are still happy to take part, you will be asked to sign a consent form.
You will then be interviewed by the researcher. This will be a series of open questions (rather than a structured questionnaire) and will require you to speak openly about your experiences. Length of individual interviews will vary, but we estimate that the interview will last around 1 hour. Interviews will be recorded using audio equipment.
You will also be asked for some background information about yourself and your church (such as age, ethnicity, training/occupational background, church denomination/affiliation, size of congregation).

What do I have to do?
You will be asked to be present at an agreed time and place to take part in the interview with the researcher. You will need to be available for the full length of the interview. You will also need to allow some time to go through this information sheet and complete the background data.

Will my taking part in this project be kept confidential?
All the information that we collect about you during the course of the research will be confidential and will be stored securely at the University of Sheffield in accordance with the Data Protection Act. Data will be kept for 5 years following completion of the study and then destroyed.

Only those directly involved in the research, and University approved transcribers will have access to this. Transcribers sign a statement of confidentiality before beginning transcription and are required to discontinue transcription if the person involved in the interview is known to them.

Extracts from the interview may be used in reports and publications, however, every effort will be made to ensure you are not identifiable in these. Names (e.g. of individuals or churches) will not be used, or will be replaced with pseudonyms.

However, in the event that anything you say leads us to be concerned about your own safety, or the safety of others, we have a duty to act on this. Similarly we cannot maintain confidentiality if we are required to pass on information for legal reasons.

What are the possible disadvantages and risks of taking part?
Although we do not anticipate any undue risks for those taking part there are some things to consider.

The interview will take up some of your time. Neither the researcher nor yourself can predict the exact details of the discussion during the interview. There is a chance that you may think back over what you talked about and not be comfortable with this. If this is the case you can contact the researcher up to 2 weeks after the interview and ask to withdraw from the study. In the unlikely event that the interview causes you any distress, you can ask to stop the interview. We would advise you to seek support from your colleagues or visit your GP.

During the interview it is likely that you will talk about your experiences working with other people. We would ask you to consider your own codes of confidentiality whilst doing this and avoid mentioning names or identifiable information. As mentioned above, if any names *are* mentioned during the interview, these will not be used, or will be replaced with pseudonyms.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for individuals participating in the project, it is hoped that this work will help us to understand the experiences of those in pastoral care roles who support people with their mental health, and have experience working with health services. We hope that this will help inform future practice in finding approaches which support peoples' spiritual and mental health needs.

What happens if the research study stops earlier than expected?
If this is the case the reason(s) should be explained to you.

Will I be recorded, and how will the recorded media be used?
The interviews will be recorded using audio tape. The audio recordings of the research interview will be transcribed into written form and used for analysis. No other use will be made of them without your written permission, and no one outside of the project will be allowed access to the original recordings.

The tapes will be stored confidentially at the University of Sheffield for as long as required. They will be disposed of after the research has been completed and they are no longer required for auditing purposes.

What will happen to the results of the research project?
The results of the overall project will be written up and submitted as a DClinPsy research thesis. Results may also be published as reports or journal articles. As mentioned above, identifiable information will not be used in any reports/publications. A copy of any publications can be obtained upon request from the researcher.

Who is organising and funding the research?
This research is funded by the NHS and the Clinical Psychology Unit at the University of Sheffield.

Expenses and payments.
We regret that we do not have sufficient funding to compensate you for any expenses incurred in participating (e.g. travel or compensation for your time) and your participation would be entirely voluntary.

Who has ethically reviewed the project?
This project has received ethical approval by the Department of Psychology's Ethics Review Committee at the University of Sheffield.

What if I want to make a complaint?
Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

Telephone: 0114 2226637

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Contact for further information
For information relating to this study please contact the primary researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Telephone messages can be left with the Research Support Officer on: 0114 2226650.
Please note: the Research Support Officer cannot answer enquiries about the project but can pass on a message to Sarah Wonders (the researcher) who will call you back.

Thank you for taking the time to read this.

Appendix iii

e) Consent form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

CONSENT FORM

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

Name of Researcher: Sarah Wonders

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated ……. for the above project and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw before, during, or up to 2 weeks after the interview without giving any reason. ☐

   (Should you choose to withdraw, you can do this by writing to Sarah Wonders at Clinical Psychology Unit, Department of Psychology, Western Bank, Sheffield, S10 2TN. Or by email pcp08sw@shef.ac.uk)

3. I understand that the interview will be recorded using audio equipment. I give permission for the interview to be recorded in this way. ☐

4. I understand that an approved transcriber who has signed a confidentiality agreement will also listen to the tapes to type them into written form. ☐

5. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my responses. ☐

6. I understand that the results of the research project may be published, and that this may include anonymised quotes from my interview. ☐

7. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

(*if different from lead researcher*) *To be signed and dated in presence of the participant*

_____	_____	_____
Lead Researcher	Date	Signature

To be signed and dated in presence of the participant

Thank you for agreeing to take part.

Appendix iii

f) Topic guide

[Introduce self and study, info sheets and consent]

1) **To begin with, I wonder if you could tell me a little bit about your role in pastoral care of your church community?**

    - What do you view as your role?
    - How would you define this role?
    - Can you give me some examples of the things you do?
        - Is there anything else you do which you have not mentioned?
    - What do you view as outside of your role?
    - How do you think other people view your role?
    - How much of your time/day/week does it take up?

2) **Can you talk a bit about your experiences supporting people with their mental health?**

    - In your role, what sorts of words do you use when talking about peoples' mental health? Are there any words or phrases that you would avoid?
    - What would be your understanding of mental health?
    - Without breaking confidentiality, or naming any individuals, can you think of an example of someone who has experienced problems with their mental health?
        - Tell me a bit about what happened with that person?
        - How did you become aware of their difficulties?
        - Describe your interactions with each other?
        - What was your understanding of the issues they were facing?
    - Have you had any other experiences before/since then?
        - How was this different? How was it similar?
    - How often do you encounter people with mental health difficulties?
        - Why do you think this is the case?
    - How do you think your church community interacts with/experiences those with mental health difficulties?

- How do those with mental health problems interact with/experience the church community?

- What are the main issues which arise when supporting people with people with their mental health?
- Are there other things which you or your church do to support people with their mental health?

3) **Could you tell me about your experiences working alongside or interacting with health professionals or health services in relation to the mental health of those in your community?**

- Can you think of a time when you have had contact with health services/professionals?
  - How did this come about?
  - What happened?
  - Who contacted who?
  - How did you feel about it?
- Was anything helpful about this? Was anything unhelpful/difficult?
- What was communication like? Did you have any similar or different points of view?

4) **Tell me about the outcome or impact of this work?**

- Did your experience have an effect on you in anyway?
  - How do you think the experience affected the person you were supporting?
  - Did you notice any impact for the health professionals?
- How did you feel about it at the time? How do you feel about it now?
- Have you learned anything from your experiences?
- Would you hope anything to be similar or different in the future?
- Is there anything you would find helpful in supporting those with mental health needs? Is there anything that you would find unhelpful?

Well, that's the end of the questions from me, but before we finish, I wondered if there's anything you wish I'd asked you more about? Is there anything you think I should have asked you that I haven't? Is there anything else you would like to say?

[Complete demographic sheet]
[Debrief. Ascertain interest in findings. Inform of likely timings and contact details.]

Appendix iii

g) Demographics sheet

Participant Demographics

Gender: Male / Female

Age:

Ethnicity:

Ordained/Lay Leader?

Years of experience in Church Ministry:

Chaplaincy experience?

Occupational history:

Highest Educational Qualification:

Personal Denomination/Church Affiliation:

Additional info of note:

Church Demographics

Size (average weekly attendance):

Catchment: Rural Urban Suburban

Demographic of congregation (age, ethnicity, SES):

Denomination/Affiliation:

How would you describe your church:

Additional info of note:

Appendix iii

h) **Extracts from analysis**

1. **Extract from coded transcript**

Theme	Text	Initial notes/coding
"Managed availability" Maintaining health of clergy and clients Christ as role model	Erm, and, but even that's a managed availability in a sense. I think it's also very destructive for the priest because it tends to, it tends to feed in to our sort of, well, counter-transference I suppose if one wants to use that sort of language, of...actually..it often tends to be an identification with, self-identification with Christ in an unhealthy way that I *ought* to be all loving, always available, always for people and therefore I can't draw any boundaries because Jesus didn't. Of course that's false because he did (small laugh), er, in fact, erm, and it's very interesting to read the Gospels with the view to exploring the question of availability, unavailability and boundary for Christ because actually there's a surprising amount in it, erm, but it, it doesn't help the client and it doesn't, it doesn't assist the priest. **R:** So..	Importance of sustaining health for client and clergy 'Meeting' me in my professional role? Christ as a role model Refer to scripture for guidance/wisdom NB. Part of his role is pastoral care of his colleagues so is this why there is a big focus on protecting professional boundaries??

Clergy-led/in charge Importance of multiple boundaries: Time, frequency, space Significance of boundaries Clergy make offering to person based on perceived need (adapting to need)	**P:** and so, yeah, I could say there's, if we look at it there's b- boundaries of time that, I make a certain amount of time available and then I will pace when I'm available in the future. I much prefer offering pastoral care, if I'm seeing somebody more than twice I would typically be seeing them once every, except during a moment of crisis, I'd be seeing them every four or six weeks so it's really quite occasional. Erm..I'd, I'd set a boundary of time and how long I would see people..I would set a boundary of space in as much as I'd almost always meet in a, erm, safe space where other people were around or in a quiet place where I'm almost observed in the cathedral and you see that [knocks] even the table here is carefully designed to, to, to keep boundaries and because there's such, has been such poor practice in boundaries of space and touching..people, erm, I..*never*..touch somebody. Erm..I very occasionally when somebody's extremely distressed I'll offer an open, a palm..an open hand..and then it's for the person to decide whether	Time management "I" = Maintaining control. Specified. Led by own model of practice. LOTS of attention and time given to emphasising boundaries! Important. Avoid isolation? Vulnerability/fear? Recognition of historical issues in church influencing current practice

Choice remains with client	they wish to hold my hand but they're holding it, and often with people who are dying or who are in enormous pain, offering a hand like that and just remaining silent with a person is the most effective engagement but even with somebody who's dying in, it's always, it's almost always possible for them to decide..to initiate touch	Individual autonomy Offering Simplicity in approach Client-led

Appendix iii

h) Extracts from analysis

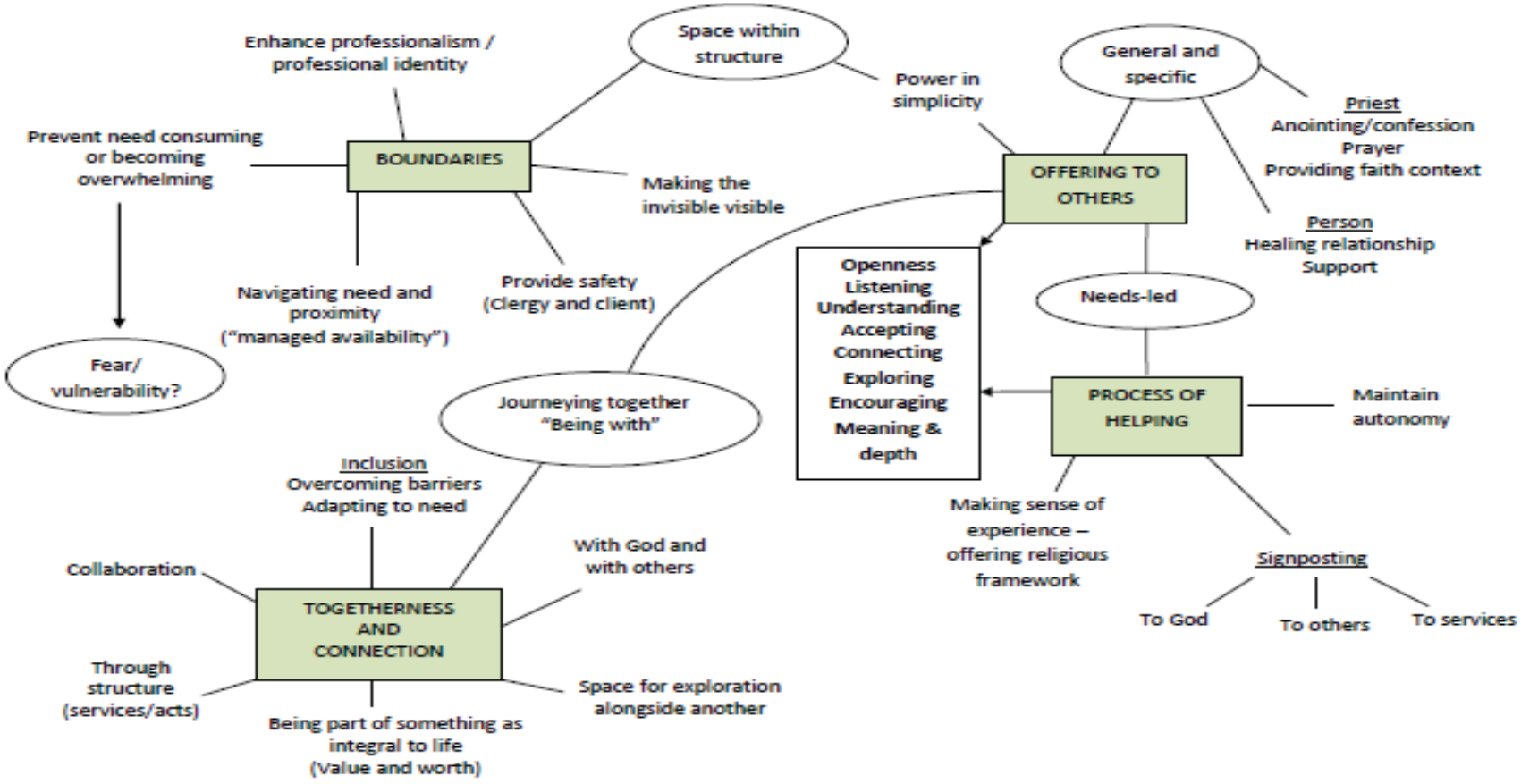
2. Extract of list of themes

Theme	Page	Line ref
Role located within hierarchy	1	4-16
Seniority and uniqueness		6, 12,
From parliament/policy to people		11-14
Pastoral role at multiple levels of system		6-14
Extensiveness of role, held within structure	2	16-19
Giving of self, receiving of others "witness"		24-28
OFFERING - safety, thought, hearing, meaning		26-28
Opportunity for exploration/meaning		27-28
Importance of clear understanding	3	37
Depth of interaction - seeing and hearing beyond the immediate		37-38
Strong, clear structure and boundaries in place (imposed?) around *collaborative* exploration		40-45
Moving forward as part of process	4	47
People seek out clergy		49
"Formula"/structure allows clergy to maintain control of interaction		50-56
Boundaries infused through interactions		53-56
Listening as a process of picking apart("tease out"), checking understanding and bringing together ("summarising")		58-61

Appendix iii

h) Extracts from analysis

3. Exemplar map


Space within structure
Enhance professionalism / professional identity
Power in simplicity
General and specific
Priest
Anointing/confession
Prayer
Providing faith context
Prevent need consuming or becoming overwhelming
BOUNDARIES
Making the invisible visible
OFFERING TO OTHERS
Person
Healing relationship
Support
Navigating need and proximity ("managed availability")
Provide safety (Clergy and client)
Openness
Listening
Understanding
Accepting
Connecting
Exploring
Encouraging
Meaning & depth
Needs-led
Fear/ vulnerability?
Journeying together "Being with"
PROCESS OF HELPING
Maintain autonomy
Inclusion
Overcoming barriers
Adapting to need
Making sense of experience – offering religious framework
Signposting
Collaboration
With God and with others
TOGETHERNESS AND CONNECTION
To God
To others
To services
Through structure (services/acts)
Space for exploration alongside another
Being part of something as integral to life (Value and worth)

Appendix iii

i) **Ordination liturgy**

Extract from the Church of England liturgy for the ordination of priests. Retrieved from:
http://www.churchofengland.org/prayer-worship/worship/texts/ordinal/priests.aspx

The Declarations

Bishop: Priests are called to be servants and shepherds among the people to whom they are sent. With their Bishop and fellow ministers, they are to proclaim the word of the Lord and to watch for the signs of God's new creation. They are to be messengers, watchmen and stewards of the Lord; they are to teach and to admonish, to feed and provide for his family, to search for his children in the wilderness of this world's temptations, and to guide them through its confusions, that they may be saved through Christ for ever. Formed by the word, they are to call their hearers to repentance and to declare in Christ's name the absolution and forgiveness of their sins.

With all God's people, they are to tell the story of God's love. They are to baptize new disciples in the name of the Father, and of the Son, and of the Holy Spirit, and to walk with them in the way of Christ, nurturing them in the faith. They are to unfold the Scriptures, to preach the word in season and out of season, and to declare the mighty acts of God. They are to preside at the Lord's table and lead his people in worship, offering with them a spiritual sacrifice of praise and thanksgiving. They are to bless the people in God's name. They are to resist evil, support the weak, defend the poor, and intercede for all in need. They are to minister to the sick and prepare the dying for their death. Guided by the Spirit, they are to discern and foster the gifts of all God's people, that the whole Church may be built up in unity and faith.

The bishop addresses the ordinands

We trust that long ago you began to weigh and ponder all this, and that you are fully determined, by the grace of God, to devote yourself wholly to his service, so that as you daily follow the rule and teaching of our Lord and grow into his likeness, God may sanctify the lives of all with whom you have to do.

Appendix i

a) **Journal approval letter**

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

21st February 2011

Sarah Wonders
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Sarah

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Mental Health, Religion and Culture

Research Report: Mental Health, Religion and Culture

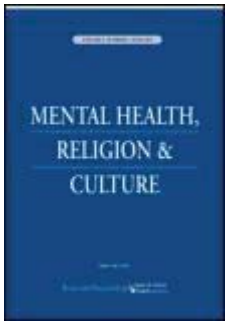
Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Dr Rebecca Knowles
Research Tutor

Appendix i

b) Notes for authors



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Instructions for Authors

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This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

The instructions below are specifically directed at authors that wish to submit a manuscript to ***Mental Health, Religion & Culture***. For general information, please visit the Publish With Us section of our website.

Mental Health, Religion & Culture **considers all manuscripts on the strict condition that they have been submitted only to** ***Mental Health, Religion & Culture*****, that they have not been published already, nor are they under consideration for publication or in press elsewhere. Authors who fail to adhere to this condition will be charged with all costs which** ***Mental Health, Religion & Culture*** **incurs and their papers will not be published.**

Contributions to ***Mental Health, Religion & Culture*** **must report original research and will be subjected to anonymous review by independent referees at the discretion of the Editorial Office.**

Manuscript submission

Manuscripts for consideration should be submitted via the ***Mental Health, Religion & Culture*** ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site, submissions should be made via the Author Centre. Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to reviewers. When uploading files authors will then be able to define the non-anonymous version as "File not for review."

Papers that specifically concern **psychiatry, anthropology, medicine and sociology** should be directed to Dr Simon Dein.

Papers that specifically concern **psychology and religious studies** should be directed either to Professor Kate Miriam Loewenthal, or Dr Christopher Alan Lewis. If in doubt, papers can be directed to any Editor.

Authors are invited to nominate up to two referees (not from their own institution) although it is not guaranteed that they will be consulted.

Books for review

Books for review should be directed to Dr Christopher Alan Lewis via the online ***Mental Health, Religion & Culture*** Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

For queries regarding book reviews, please contact Dr C.A. Lewis at: School of Psychology, University of Ulster at Magee College, Northland Road, Londonderry BT48 7JL, Northern Ireland (tel: +44(0)2871 375301; fax +44(0)2871 375402)

Manuscript preparation:

1. General guidelines

- Papers are accepted English. British English spelling and punctuation is preferred.
- A typical article may be between **5,000** and **10,000 words**. A short article for rapid publication will not exceed **2,000 words**. Papers that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendices (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- An abstract of no more than 150 words is required for all papers submitted.
- Each paper should have between three and seven keywords.
- The title page should include the title of the paper, all the authors' full names, affiliations, postal addresses, telephone and fax numbers and email addresses. One author should be identified as the Corresponding Author at the bottom of the page. An abbreviated title should also be given, for running headlines within the article.
- Biographical notes on contributors are not required for this journal.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal's article style, Quick guide
- Description of the Journal's reference style, Quick guide
- Manuscripts may be submitted in any standard format, including Word, PostScript and PDF. These files will be automatically converted into a PDF file for the review process.
- This journal does not accept Microsoft Word 2007 documents.
- Please use British spelling (e.g. colour, organise). Use double quotation marks with single within if needed.

If you have any questions about references or formatting your article, please contact authorqueries@tandf.co.uk (please mention the journal title in your email).

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3. Figures

We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each figure should be numbered with Figure number (Arabic numerals).
- Figures must be saved separate to text. Please do not embed figures in the main document.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the paper (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly. Captions should include keys to symbols, and should make interpretation possible without reference to the text.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Please note that it is in the author's interest to provide the highest quality figure format possible. Please do not hesitate to contact our Production Department if you have any queries.

4. Tables

Tables should be numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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- **Copyright permission letter template**

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Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

7. Code of experimental ethics and practice and confidentiality

Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the Editor if they wish.

8. Conflict of Interests

All authors of accepted articles will be required to complete a declaration of competing interests and/or financial support.

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- First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.
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- Third-level headings should be in italics, with an initial capital letter for any proper nouns.
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Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. The actual tables and figures should be supplied either at the end of the text or in a separate file as requested by the Editor. Ensure you have permission to use any figures you are reproducing from another source. Advice on artwork is available here.

Running heads and **received dates** are not required when submitting a manuscript for review.

If your article is accepted for publication, it will be copy-edited and typeset in the correct style for the journal.

If you have any queries, please contact us at authorqueries@tandf.co.uk, mentioning the full title of the journal you are interested in, or see our Author Services homepage.

Appendix ii

a) **Ethical approval**

------ Forwarded Message

Date: Thu, 24 Jun 2010 09:51:26 +0100

To: <G.Rowse@sheffield.ac.uk>

Subject: Approval of your research proposal

Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals. " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,

Prof Paschal Sheeran

Chair, DESC

------ End of Forwarded Message

Appendix ii

b) Governance approval

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

6th June 2010

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals
Investigators: Sarah Wonders (DClin Psy Trainee, University of Sheffield); Dr Georgina Rowse, Dr Andrew Thompson (Academic Supervisors, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it, and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

Dr. Rebecca Knowles
Research Tutor

Co. Sarah Wonders, Dr Georgina Rowse, Dr Andrew Thompson

-------- Original Message --------

Subject: Your project in URMS, 128956, has now been authorised

Date: 14 Jul 10 14:50:30

From: noreply@sheffield.ac.uk

To: C.Harrison@sheffield.ac.uk

Project code: 128956

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals (Sarah Wonders)

This project has now been checked and authorised by the Research Office. Relevant details can now be transferred to any application forms or documentation. Please note that you should use figures from a project report with the status COSTING APPROVED to ensure you have the finalised figures.

Please note that staff named as Principal Investigator or co-Investigator on the "Investigators" page of the URMS record can access the costing and can, therefore, necessarily see the salaries of staff costed on the grant. Staff salary information is only made available for the purpose of calculating the cost of an application, is strictly confidential and should not be discussed.

Should you have any queries relating to the costs, please contact the URMS helpline on 21450.

GUIDANCE ON URMS PROJECTS AT THE "COSTING APPROVED" STAGE

1. Research applications require Institutional authorisation before submission to the funder. Completed hardcopy applications should be either mailed or dropped off at the Research Office (via the "Research Applications" mailbox) together with any requisite supporting paperwork such as procurement forms or letters of support, and contact details for any queries.

Applications with a full economic cost value less than GBP 750,000 received before noon on any working day will be available for collection by noon the following working day. Applications received after noon will be available by 5pm the following working day. Applications can be returned to departments via mail if required.

Applications with a full economic cost value greater than GBP 750,000 require four days for authorisation due to the availability of the small number of authorised signatories above this amount.

Please note that these timescales also apply to electronic applications.

2. If the Department of Health's "Research Governance Framework" is applicable to the project and external or additional funding is not being sought, e.g. "own account" or student research projects, the project will not be moved to APPLICATION AUTHORISED until the Research Office has received written confirmation of which organisation is the project's Research Governance sponsor.

3. There are several web resources available to staff on the Research Office website, including:

Information regarding University processes for research costing, applications and contracts at: http://www.sheffield.ac.uk/researchoffice/overview/contract.html

Guidance on Research Governance, Clinical Trials & Ethics (and access to the Good Research Practice Standards) at: http://www.sheffield.ac.uk/researchoffice/gov_ethics_grp/governance

General advice and guidance regarding research applications at: http://www.sheffield.ac.uk/researchoffice/advice

********** Research Office New Spring House 231 Glossop Road Sheffield S10 2GW

URMS Helpline: 21450 http://www.sheffield.ac.uk/researchoffice/

Appendix iii

a) Recruitment letter

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

June 2010

Pastoral care and supporting people with their mental health.

Dear Church Leader

I am a Trainee Clinical Psychologist conducting research on spiritual needs and mental health care. I am doing a study specifically focusing on the **experiences of those providing pastoral care** in supporting people in their community with their mental health. This may include ordained clergy, lay leaders or people with designated pastoral responsibilities. The results of this research will be written up as part of a doctoral (DClinPsy) thesis and may also be used for reports and publications.

There are two parts to this study:

- An interview (I will send you more information about this only if you indicate interest).
- A survey (which you can complete online now).

You can choose whether you would like to take part in either, neither or both of these.

(1) First, I would be grateful if you could take a moment to answer some brief screening questions. This should take less than 1 minute of your time. You can access these questions by clicking on this link: (SURVEYMONKEY LINK).

There will be a space for you to provide your contact details if you think you might be interested in taking part in an interview. If so, I will then send you further information about this to help you decide whether you wish to take part.

(2) Next, you will be connected to an online survey. You can complete this even if you do not want to take part in an interview. This should take up to 10 minutes of your time.

Please pass this information on to anyone else you know in a pastoral or church leadership role who may be interested.

If you do not have access to the internet but still wish to take part, you can leave a message for me with the Research Support Officer on 0114 2226650 and I will contact you.

If you have any questions about this study you can contact me by email on pcp08sw@shef.ac.uk or in writing at the address above.

Thank you for taking the time to read this.

With best wishes,

Sarah Wonders
Trainee Clinical Psychologist

Appendix iii

b) Screening questions

Pastoral care and supporting people with mental health difficulties.

Thank you for taking an interest in this study.

The following questions are part of a research project which has received ethical approval from the University of Sheffield. The research forms part of a doctoral (DClinPsy) thesis. Completion of this information is entirely voluntary. If you do not want to answer the questions below, you do not have to. If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Any returned information may be collated and reported in future publications. By submitting this you are consenting for the information you provide to be used in this way. Any information which identifies you will not be used. Data will be stored securely at the University of Sheffield in compliance with the Data Protection Act.

1) Do you regard yourself as a Christian leader or provider of pastoral care within a Christian community? **YES/NO**

2) Do you also work as a hospital chaplain? **YES/NO**

3) Are you aware of any people in your church community with mental health problems? **YES/NO**

4) Have you been involved with supporting individuals in your church community who have difficulties with their mental health? **YES/NO**

5) How much experience have you had **interacting with health services** (e.g. GP's, mental health teams, social workers, mental health nurses, care coordinators, counsellors, psychologists, psychiatrists) in supporting those with mental health problems in your faith community?

NONE **A LITTLE** **A MODERATE AMOUNT** **A LOT**

6) Would you consider participating in a research interview? **YES/NO**

If YES to question 6: Please complete your contact details below so that I can contact you at a later date. These details will be stored confidentially and will **only** be used to contact you. They will not be passed on to any third parties. You will be provided with further information before deciding whether you want to take part.

Name
Address
Email
Phone Number

Thank you.

[Click to submit]

We would now like to invite you to complete a short survey about mental health, your church community and your pastoral role. This should take no longer than 10 minutes of your time. Your answers will remain anonymous.

[Yes please, go to survey] **[No thanks, I do not want to complete the survey]**

Appendix iii

c) Online survey

Pastoral care and supporting people with their mental health[1]

We would like to find out about the experiences of those providing pastoral care within Christian church communities. The following survey asks you some questions about you and your role, your church, your views about mental health, working with health and social care services and support and training. It should take no longer than 10 minutes of your time. The survey is part of a research project which contributes to a doctoral (DClinPsy) thesis. It has received ethical approval from the University of Sheffield. Completion of the survey is voluntary. If you do not want to answer the questions below, you do not have to. You can exit the survey at any time by closing this internet window. The survey is anonymous, therefore once you have submitted your answers, it will not be possible to withdraw your data from the study. All data will be transmitted and stored securely and will be kept at the University of Sheffield. Data will only be accessed by those involved in the research and will be destroyed 5 years after the completion of the study.

Any returned information may be collated and reported (anonymously) in future publications. By submitting your answers you are consenting for the information you provide to be used in this way.

If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Thank you for your time

I have read and understand the information above [Y/N]
I understand that my participation is voluntary and that I do not have to complete the survey if I do not want to [Y/N]
I give consent to take part in this survey [Y/N]

About you.....

1. **Gender** [M/F]
2. **Age** [18-25, 26-35, 36-45, 46-55, 56-65, 66-75, 76+]
3. **First part of your church postcode only (e.g. S2, S17, NG5)** [Open text box – limit to 4 characters if possible]
4. **Would you regard your church as:** [Urban, Suburban, Rural]
5. **Church denomination** [Anglican, Methodist, Catholic, Baptist, Pentecostal, United Reformed, Salvation Army, Independent, Other (please state)]
6. **What is the estimated size of your church community (based on average weekly attendance)?** [Less than 50, 50-199, 200-499, 500-1000, More than 1000]
7. **How would you describe your current role in relation to the pastoral care you provide (e.g. youth worker, pastoral advisor, church leader)** [Open question]
8. **How many years of experience do you have overall in pastoral care role(s)** [0-5, 6-15, 16-25, 26-35, 35+]

[1] Please note this questionnaire was formatted appropriately when created on surveymonkey. This is an example of the content of the survey with response categories provided in brackets.

9. **Do you have additional qualifications in any of the following**: [Nursing, Counselling, Social Work, Medicine, Psychology, Other Health Profession?]
10. **Have you ever experienced mental health difficulties of your own?** [Y/N/prefer not to answer]
11. **Have your own experiences of mental health difficulties helped you in the care you provide to those in your community?**
    [N/A,They are irrelevant/unhelpful, Helpful if kept to myself, Helpful if shared with others]

We would be grateful if you could answer the following questions in relation to your role over the **past 5 years**.

<u>About your church and supporting people with their mental health....</u>

12. **Are you aware of any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
13. **Have you been involved in supporting any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
14. **How often do you discuss mental health issues with those in your pastoral care?**
[Never, very occasionally, occasionally, often, always]
15. **In the past 5 years, how many times have you been involved in *supporting* someone in your community with their mental health?**
    [Never, 1-5, 6-10, 11-15, 16-20, more than 20 times]
16. **What does the support you offer involve? [Open question]**
17. **In your role, are there activities that you are involved with that promote peoples' mental health and wellbeing?**
    [Yes (please specify-text box)/No]
18. **Does your church actively provide services (e.g. groups, courses) which specifically have a role in promoting or maintaining peoples' mental health?**
    [Yes (please specify-text box), No]

<u>Your views about mental health and wellbeing.....</u>

Please indicate your agreement with the following statements:

19. **Mental health is a topic which is relevant for the church**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
20. **I feel I have a good understanding of these issues**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
21. **I am confident in my ability to *notice* if somebody is experiencing difficulties in this area**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
22. **I am confident in supporting somebody with their mental health**

[Strongly agree – agree – unsure - disagree – strongly disagree]

23. **It is not part of my role to help support people with their mental health**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
24. **I usually know when somebody needs more help than I am able to offer (e.g. needs help from health services)**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
25. **It is difficult to distinguish between spiritual difficulties and mental health difficulties**
    [Strongly agree – agree – unsure - disagree – strongly disagree]

<u>Working with health and social care services.....</u>

26. **In the past 5 years, how often have you referred someone in your care to a health professional?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If never, please go to question [number])
27. **Who have you referred people to? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, MH chaplain, Counsellor, Other (please specify)]
28. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
29. **In the past 5 years, how often have you contacted a health professional for joint-working or advice?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If 'never' please go to Question [number])
30. **Who have you contacted? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor, Other (please specify)]
31. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
32. **Why did you make the referral or seek consultation?**
    [Open Q – text box]
33. **If you have never or rarely made a referral or sought consultation, what are the reasons for this?**
    [Not necessary, didn't think of it, didn't know how to refer, worried that health professionals won't understand person's faith, *patient did not want me to, it was not my responsibility, don't know when this is necessary, other (PLEASE SPECIFY)]*
34. **In what circumstances do you think that it would it be helpful to refer to a mental health professional? (Please select all which apply)**
    [Only if requested by person, when person is risk to self/others, person experiencing irrational thoughts/fears, when family/friends worried, when person thinks they are possessed, when experiencing religious delusions, other (please specify)]
35. **Do you know who your local chaplain is*? [Y/N]***
36. **In the past 5 years, has a health professional ever referred someone to you, or consulted you for advice in relation to a patient?**

[Never, once, 2-4 times, 5-7 times, 8 times or more]

37. **What was the profession of the person who contacted you? (Please select all that apply)**
    [N/A, GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor (NHS), Counsellor (Private), Counsellor (Religious), Other (PLEASE SPECIFY)]
38. **Generally, has your experience of working with health professionals been *helpful* in supporting member(s) of your community?**
    [Very much, mostly, a little bit, not at all]
39. **How would you rate the *communication* which you have received from the health professionals?**
    [Very poor, poor, adequate, good, very good]
40. **Generally, how much did you feel you had a shared understanding with the health professionals of the person's difficulties**
    [Very much, mostly, a little bit, not at all]
41. **How much did you feel you agreed about the best way to support the person and help manage their difficulties?**
    [Very much, mostly, a little bit, not at all]
42. **Did you receive any feedback from the health service staff, keeping you informed of the situation or of their actions?**
    [yes/no]
43. **Were there opportunites to work with or alongside the health professional(s) to support the person**
    [yes/no]
44. **How much did you feel that your role and opinion was valued by the health professional?**
    [Very much, mostly, a little bit, not at all]
45. **How much did you feel that your role and opinion was valued by the person in your community?**
    [Very much, mostly, a little bit, not at all]

<u>About support for you.....</u>

46. **Did you receive any training in mental health before qualifying/starting in your role?**
    [None, very little, adequate, a lot]
47. **Have you received any training in mental health since qualifying/starting in your role?**
    [None, very little, adequate, a lot]
48. **Do you feel that you and your wider church community are able to support those with mental health difficulties?**
    [Always, most of the time, sometimes, rarely, never]
49. **What kind of training or information about mental health care would you find most helpful now?**
    [None needed, promoting mental health/prevention of difficulties, warning signs/detection of difficulties, information about mental health difficulties and how to manage them , how to discern between mental and spiritual ill health, referral routes/confidentiality/data protection, knowing when to refer, other (PLEASE SPECIFY)]

Additional comments.....

Finally, is there anything else you would like to say? Are there any areas that you think have been overlooked? Is there anything else that you think it is important for researchers to consider?

[OPEN RESPONSE]

[FINISH AND SUBMIT MY ANSWERS!]

Thank you for taking the time to complete this survey.

If you have any questions regarding this study, please contact the researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Appendix iii

d) Information sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

INFORMATION SHEET

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take some time to decide whether or not you would like to take part. You can discuss this with others if you wish. Please ask if there is anything that is unclear or if you would like more information.

What is the purpose of the project?
We know that many people experience mental health difficulties at some point in their life. During times of distress people often turn to people they trust for help and support. They may also seek help from health services. Recent government guidelines recommend that effective links should be made between faith groups and health services.

This study aims to explore community-based Christian leaders'[2] *experiences* of providing pastoral support to members of their community with mental health needs. We do not know very much about this yet and would like to learn more. This research project forms part of a Doctoral DClinPsy thesis due for submission in July 2011.

Why have I been chosen?
You have indicated that you have some experience supporting people in your community with their mental health, and interacting with health care services. We are interested in hearing about your experiences. You have been selected from local Christian leaders who have experience in these areas and expressed an interest in participating in research.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You can still

[2] This includes ordained clergy, lay leaders and those with designated responsibilities in pastoral care roles.

withdraw from the research at any time before, during or up to 2 weeks after the interview. You do not have to give a reason.

What will happen to me if I take part?
If you decide to take part, you will be visited by a researcher at a location which is convenient to you. The interview will need to take place in a quiet/confidential environment. If this is not possible at your place of work or residence, arrangements may be made to conduct the interviews at the university site.
You will go through this information sheet with the researcher and be given the opportunity to ask questions. If you are still happy to take part, you will be asked to sign a consent form.
You will then be interviewed by the researcher. This will be a series of open questions (rather than a structured questionnaire) and will require you to speak openly about your experiences. Length of individual interviews will vary, but we estimate that the interview will last around 1 hour. Interviews will be recorded using audio equipment.
You will also be asked for some background information about yourself and your church (such as age, ethnicity, training/occupational background, church denomination/affiliation, size of congregation).

What do I have to do?
You will be asked to be present at an agreed time and place to take part in the interview with the researcher. You will need to be available for the full length of the interview. You will also need to allow some time to go through this information sheet and complete the background data.

Will my taking part in this project be kept confidential?
All the information that we collect about you during the course of the research will be confidential and will be stored securely at the University of Sheffield in accordance with the Data Protection Act. Data will be kept for 5 years following completion of the study and then destroyed.

Only those directly involved in the research, and University approved transcribers will have access to this. Transcribers sign a statement of confidentiality before beginning transcription and are required to discontinue transcription if the person involved in the interview is known to them.

Extracts from the interview may be used in reports and publications, however, every effort will be made to ensure you are not identifiable in these. Names (e.g. of individuals or churches) will not be used, or will be replaced with pseudonyms.

However, in the event that anything you say leads us to be concerned about your own safety, or the safety of others, we have a duty to act on this. Similarly we cannot maintain confidentiality if we are required to pass on information for legal reasons.

What are the possible disadvantages and risks of taking part?
Although we do not anticipate any undue risks for those taking part there are some things to consider.

The interview will take up some of your time. Neither the researcher nor yourself can predict the exact details of the discussion during the interview. There is a chance that you may think back over what you talked about and not be comfortable with this. If this is the case you can contact the researcher up to 2 weeks after the interview and ask to withdraw from the study. In the unlikely event that the interview causes you any distress, you can ask to stop the interview. We would advise you to seek support from your colleagues or visit your GP.

During the interview it is likely that you will talk about your experiences working with other people. We would ask you to consider your own codes of confidentiality whilst doing this and avoid mentioning names or identifiable information. As mentioned above, if any names *are* mentioned during the interview, these will not be used, or will be replaced with pseudonyms.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for individuals participating in the project, it is hoped that this work will help us to understand the experiences of those in pastoral care roles who support people with their mental health, and have experience working with health services. We hope that this will help inform future practice in finding approaches which support peoples' spiritual and mental health needs.

What happens if the research study stops earlier than expected?
If this is the case the reason(s) should be explained to you.

Will I be recorded, and how will the recorded media be used?
The interviews will be recorded using audio tape. The audio recordings of the research interview will be transcribed into written form and used for analysis. No other use will be made of them without your written permission, and no one outside of the project will be allowed access to the original recordings.

The tapes will be stored confidentially at the University of Sheffield for as long as required. They will be disposed of after the research has been completed and they are no longer required for auditing purposes.

What will happen to the results of the research project?
The results of the overall project will be written up and submitted as a DClinPsy research thesis. Results may also be published as reports or journal articles. As mentioned above, identifiable information will not be used in any reports/publications. A copy of any publications can be obtained upon request from the researcher.

Who is organising and funding the research?
This research is funded by the NHS and the Clinical Psychology Unit at the University of Sheffield.

Expenses and payments.
We regret that we do not have sufficient funding to compensate you for any expenses incurred in participating (e.g. travel or compensation for your time) and your participation would be entirely voluntary.

Who has ethically reviewed the project?
This project has received ethical approval by the Department of Psychology's Ethics Review Committee at the University of Sheffield.

What if I want to make a complaint?
Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

Telephone: 0114 2226637

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Contact for further information
For information relating to this study please contact the primary researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Telephone messages can be left with the Research Support Officer on: 0114 2226650.
Please note: the Research Support Officer cannot answer enquiries about the project but can pass on a message to Sarah Wonders (the researcher) who will call you back.

Thank you for taking the time to read this.

Appendix iii

e) Consent form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

CONSENT FORM

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

Name of Researcher: Sarah Wonders

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated ……. for the above project and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw before, during, or up to 2 weeks after the interview without giving any reason. ☐

   (Should you choose to withdraw, you can do this by writing to Sarah Wonders at Clinical Psychology Unit, Department of Psychology, Western Bank, Sheffield, S10 2TN. Or by email pcp08sw@shef.ac.uk)

3. I understand that the interview will be recorded using audio equipment. I give permission for the interview to be recorded in this way. ☐

4. I understand that an approved transcriber who has signed a confidentiality agreement will also listen to the tapes to type them into written form. ☐

5. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my responses. ☐

6. I understand that the results of the research project may be published, and that this may include anonymised quotes from my interview. ☐

7. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

(*if different from lead researcher*) *To be signed and dated in presence of the participant*

_____	_____	_____
Lead Researcher	Date	Signature

To be signed and dated in presence of the participant

Thank you for agreeing to take part.

Appendix iii

f) Topic guide

[Introduce self and study, info sheets and consent]

1) **To begin with, I wonder if you could tell me a little bit about your role in pastoral care of your church community?**

    - What do you view as your role?
    - How would you define this role?
    - Can you give me some examples of the things you do?
        - Is there anything else you do which you have not mentioned?
    - What do you view as outside of your role?
    - How do you think other people view your role?
    - How much of your time/day/week does it take up?

2) **Can you talk a bit about your experiences supporting people with their mental health?**

    - In your role, what sorts of words do you use when talking about peoples' mental health? Are there any words or phrases that you would avoid?
    - What would be your understanding of mental health?
    - Without breaking confidentiality, or naming any individuals, can you think of an example of someone who has experienced problems with their mental health?
        - Tell me a bit about what happened with that person?
        - How did you become aware of their difficulties?
        - Describe your interactions with each other?
        - What was your understanding of the issues they were facing?
    - Have you had any other experiences before/since then?
        - How was this different? How was it similar?
    - How often do you encounter people with mental health difficulties?
        - Why do you think this is the case?
    - How do you think your church community interacts with/experiences those with mental health difficulties?

- How do those with mental health problems interact with/experience the church community?

- What are the main issues which arise when supporting people with people with their mental health?
- Are there other things which you or your church do to support people with their mental health?

3) **Could you tell me about your experiences working alongside or interacting with health professionals or health services in relation to the mental health of those in your community?**

- Can you think of a time when you have had contact with health services/professionals?
  - How did this come about?
  - What happened?
  - Who contacted who?
  - How did you feel about it?
- Was anything helpful about this? Was anything unhelpful/difficult?
- What was communication like? Did you have any similar or different points of view?

4) **Tell me about the outcome or impact of this work?**

- Did your experience have an effect on you in anyway?
  - How do you think the experience affected the person you were supporting?
  - Did you notice any impact for the health professionals?
- How did you feel about it at the time? How do you feel about it now?
- Have you learned anything from your experiences?
- Would you hope anything to be similar or different in the future?
- Is there anything you would find helpful in supporting those with mental health needs? Is there anything that you would find unhelpful?

Well, that's the end of the questions from me, but before we finish, I wondered if there's anything you wish I'd asked you more about? Is there anything you think I should have asked you that I haven't? Is there anything else you would like to say?

[Complete demographic sheet]
[Debrief. Ascertain interest in findings. Inform of likely timings and contact details.]

Appendix iii

g) Demographics sheet

Participant Demographics

Gender: Male / Female

Age:

Ethnicity:

Ordained/Lay Leader?

Years of experience in Church Ministry:

Chaplaincy experience?

Occupational history:

Highest Educational Qualification:

Personal Denomination/Church Affiliation:

Additional info of note:

Church Demographics

Size (average weekly attendance):

Catchment: Rural Urban Suburban

Demographic of congregation (age, ethnicity, SES):

Denomination/Affiliation:

How would you describe your church:

Additional info of note:

Appendix iii

h) **Extracts from analysis**

1. **Extract from coded transcript**

Theme	Text	Initial notes/coding
"Managed availability" Maintaining health of clergy and clients Christ as role model	Erm, and, but even that's a managed availability in a sense. I think it's also very destructive for the priest because it tends to, it tends to feed in to our sort of, well, counter-transference I suppose if one wants to use that sort of language, of...actually..it often tends to be an identification with, self-identification with Christ in an unhealthy way that I *ought* to be all loving, always available, always for people and therefore I can't draw any boundaries because Jesus didn't. Of course that's false because he did (small laugh), er, in fact, erm, and it's very interesting to read the Gospels with the view to exploring the question of availability, unavailability and boundary for Christ because actually there's a surprising amount in it, erm, but it, it doesn't help the client and it doesn't, it doesn't assist the priest. **R:** So..	Importance of sustaining health for client and clergy 'Meeting' me in my professional role? Christ as a role model Refer to scripture for guidance/wisdom NB. Part of his role is pastoral care of his colleagues so is this why there is a big focus on protecting professional boundaries??

Clergy-led/in charge Importance of multiple boundaries: Time, frequency, space Significance of boundaries Clergy make offering to person based on perceived need (adapting to need)	**P:** and so, yeah, I could say there's, if we look at it there's b- boundaries of time that, I make a certain amount of time available and then I will pace when I'm available in the future. I much prefer offering pastoral care, if I'm seeing somebody more than twice I would typically be seeing them once every, except during a moment of crisis, I'd be seeing them every four or six weeks so it's really quite occasional. Erm..I'd, I'd set a boundary of time and how long I would see people..I would set a boundary of space in as much as I'd almost always meet in a, erm, safe space where other people were around or in a quiet place where I'm almost observed in the cathedral and you see that [knocks] even the table here is carefully designed to, to, to keep boundaries and because there's such, has been such poor practice in boundaries of space and touching..people, erm, I..*never*..touch somebody. Erm..I very occasionally when somebody's extremely distressed I'll offer an open, a palm..an open hand..and then it's for the person to decide whether	Time management "I" = Maintaining control. Specified. Led by own model of practice. LOTS of attention and time given to emphasising boundaries! Important. Avoid isolation? Vulnerability/fear? Recognition of historical issues in church influencing current practice

Choice remains with client	they wish to hold my hand but they're holding it, and often with people who are dying or who are in enormous pain, offering a hand like that and just remaining silent with a person is the most effective engagement but even with somebody who's dying in, it's always, it's almost always possible for them to decide..to initiate touch	Individual autonomy Offering Simplicity in approach Client-led

Appendix iii

h) Extracts from analysis

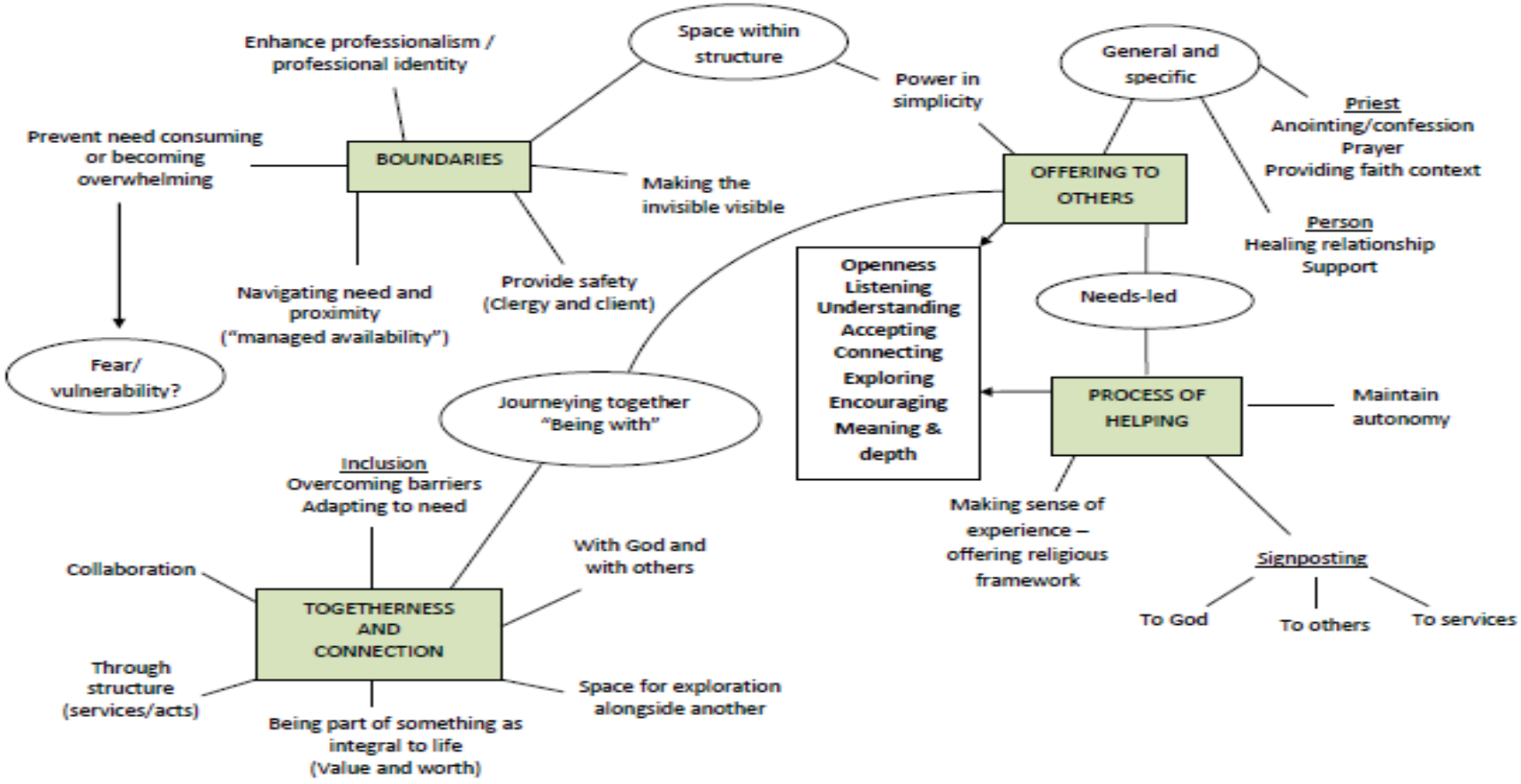
2. Extract of list of themes

Theme	Page	Line ref
Role located within hierarchy	1	4-16
Seniority and uniqueness		6, 12,
From parliament/policy to people		11-14
Pastoral role at multiple levels of system		6-14
Extensiveness of role, held within structure	2	16-19
Giving of self, receiving of others "witness"		24-28
OFFERING - safety, thought, hearing, meaning		26-28
Opportunity for exploration/meaning		27-28
Importance of clear understanding	3	37
Depth of interaction - seeing and hearing beyond the immediate		37-38
Strong, clear structure and boundaries in place (imposed?) around *collaborative* exploration		40-45
Moving forward as part of process	4	47
People seek out clergy		49
"Formula"/structure allows clergy to maintain control of interaction		50-56
Boundaries infused through interactions		53-56
Listening as a process of picking apart("tease out"), checking understanding and bringing together ("summarising")		58-61

Appendix iii

h) Extracts from analysis

3. Exemplar map


Space within structure
Enhance professionalism / professional identity
Power in simplicity
General and specific
Priest
Anointing/confession
Prayer
Providing faith context
Prevent need consuming or becoming overwhelming
BOUNDARIES
Making the invisible visible
OFFERING TO OTHERS
Person
Healing relationship
Support
Navigating need and proximity ("managed availability")
Provide safety (Clergy and client)
Openness
Listening
Understanding
Accepting
Connecting
Exploring
Encouraging
Meaning & depth
Needs-led
Fear/ vulnerability?
Journeying together "Being with"
PROCESS OF HELPING
Maintain autonomy
Inclusion
Overcoming barriers
Adapting to need
Making sense of experience – offering religious framework
Signposting
Collaboration
With God and with others
TOGETHERNESS AND CONNECTION
To God
To others
To services
Through structure (services/acts)
Space for exploration alongside another
Being part of something as integral to life (Value and worth)

Appendix iii

i) **Ordination liturgy**

Extract from the Church of England liturgy for the ordination of priests. Retrieved from:
http://www.churchofengland.org/prayer-worship/worship/texts/ordinal/priests.aspx

The Declarations

Bishop: Priests are called to be servants and shepherds among the people to whom they are sent. With their Bishop and fellow ministers, they are to proclaim the word of the Lord and to watch for the signs of God's new creation. They are to be messengers, watchmen and stewards of the Lord; they are to teach and to admonish, to feed and provide for his family, to search for his children in the wilderness of this world's temptations, and to guide them through its confusions, that they may be saved through Christ for ever. Formed by the word, they are to call their hearers to repentance and to declare in Christ's name the absolution and forgiveness of their sins.

With all God's people, they are to tell the story of God's love. They are to baptize new disciples in the name of the Father, and of the Son, and of the Holy Spirit, and to walk with them in the way of Christ, nurturing them in the faith. They are to unfold the Scriptures, to preach the word in season and out of season, and to declare the mighty acts of God. They are to preside at the Lord's table and lead his people in worship, offering with them a spiritual sacrifice of praise and thanksgiving. They are to bless the people in God's name. They are to resist evil, support the weak, defend the poor, and intercede for all in need. They are to minister to the sick and prepare the dying for their death. Guided by the Spirit, they are to discern and foster the gifts of all God's people, that the whole Church may be built up in unity and faith.

The bishop addresses the ordinands

We trust that long ago you began to weigh and ponder all this, and that you are fully determined, by the grace of God, to devote yourself wholly to his service, so that as you daily follow the rule and teaching of our Lord and grow into his likeness, God may sanctify the lives of all with whom you have to do.

Appendix i

a) **Journal approval letter**

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

21st February 2011

Sarah Wonders
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Sarah

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Mental Health, Religion and Culture

Research Report: Mental Health, Religion and Culture

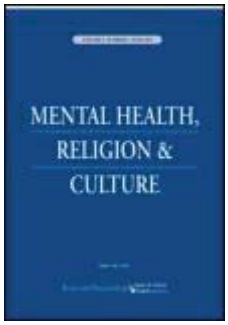
Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Dr Rebecca Knowles
Research Tutor

Appendix i

b) Notes for authors



Mental Health, Religion & Culture

Published By: Routledge
Volume Number: 14

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Print ISSN: 1367-4676

Online ISSN: 1469-9737

Instructions for Authors

SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

The instructions below are specifically directed at authors that wish to submit a manuscript to ***Mental Health, Religion & Culture***. For general information, please visit the Publish With Us section of our website.

Mental Health, Religion & Culture **considers all manuscripts on the strict condition that they have been submitted only to** ***Mental Health, Religion & Culture*****, that they have not been published already, nor are they under consideration for publication or in press elsewhere. Authors who fail to adhere to this condition will be charged with all costs which** ***Mental Health, Religion & Culture*** **incurs and their papers will not be published.**

Contributions to ***Mental Health, Religion & Culture*** **must report original research and will be subjected to anonymous review by independent referees at the discretion of the Editorial Office.**

Manuscript submission

Manuscripts for consideration should be submitted via the ***Mental Health, Religion & Culture*** ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site, submissions should be made via the Author Centre. Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to reviewers. When uploading files authors will then be able to define the non-anonymous version as "File not for review."

Papers that specifically concern **psychiatry, anthropology, medicine and sociology** should be directed to Dr Simon Dein.

Papers that specifically concern **psychology and religious studies** should be directed either to Professor Kate Miriam Loewenthal, or Dr Christopher Alan Lewis. If in doubt, papers can be directed to any Editor.

Authors are invited to nominate up to two referees (not from their own institution) although it is not guaranteed that they will be consulted.

Books for review

Books for review should be directed to Dr Christopher Alan Lewis via the online ***Mental Health, Religion & Culture*** Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

For queries regarding book reviews, please contact Dr C.A. Lewis at: School of Psychology, University of Ulster at Magee College, Northland Road, Londonderry BT48 7JL, Northern Ireland (tel: +44(0)2871 375301; fax +44(0)2871 375402)

Manuscript preparation:

1. General guidelines

- Papers are accepted English. British English spelling and punctuation is preferred.
- A typical article may be between **5,000** and **10,000 words**. A short article for rapid publication will not exceed **2,000 words**. Papers that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendices (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- An abstract of no more than 150 words is required for all papers submitted.
- Each paper should have between three and seven keywords.
- The title page should include the title of the paper, all the authors' full names, affiliations, postal addresses, telephone and fax numbers and email addresses. One author should be identified as the Corresponding Author at the bottom of the page. An abbreviated title should also be given, for running headlines within the article.
- Biographical notes on contributors are not required for this journal.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal's article style, Quick guide
- Description of the Journal's reference style, Quick guide
- Manuscripts may be submitted in any standard format, including Word, PostScript and PDF. These files will be automatically converted into a PDF file for the review process.
- This journal does not accept Microsoft Word 2007 documents.
- Please use British spelling (e.g. colour, organise). Use double quotation marks with single within if needed.

If you have any questions about references or formatting your article, please contact authorqueries@tandf.co.uk (please mention the journal title in your email).

Word templates
Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk

3. Figures

We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each figure should be numbered with Figure number (Arabic numerals).
- Figures must be saved separate to text. Please do not embed figures in the main document.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the paper (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly. Captions should include keys to symbols, and should make interpretation possible without reference to the text.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Please note that it is in the author's interest to provide the highest quality figure format possible. Please do not hesitate to contact our Production Department if you have any queries.

4. Tables

Tables should be numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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- **Copyright permission letter template**

6. Informed consent

Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

7. Code of experimental ethics and practice and confidentiality

Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the Editor if they wish.

8. Conflict of Interests

All authors of accepted articles will be required to complete a declaration of competing interests and/or financial support.

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Author Services

Advice to authors on preparing a manuscript

NB: Please follow any specific instructions for authors provided by the Editor of the journal

Font: Times New Roman, 12 point. Use margins of at least 2.5 cm (1 inch).

Title: Use bold for your article title, with an initial capital letter for any proper nouns.

Authors' names: Give the names of all contributing authors on the title page exactly as you wish them to appear in the published article.

Affiliations: List the affiliation of each author (department, university, city, and country).

Correspondence details: Please provide an institutional email address for the corresponding author. Full postal details are also needed by the publisher, but will not necessarily be published.

Anonymity for peer review: Ensure your identity and that of your co-authors is not revealed in the text of your article or in your manuscript files when submitting the manuscript for review. Advice on anonymizing your manuscript is available here.

Abstract: Indicate the abstract paragraph with a heading or by reducing the font size. Advice on writing abstracts is available here.

Keywords: Please provide five or six keywords to help readers find your article. Advice on selecting suitable keywords is available here.

Headings: Please indicate the level of the section headings in your article:

- First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.
- Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.
- Third-level headings should be in italics, with an initial capital letter for any proper nouns.
- Fourth-level headings should also be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. The actual tables and figures should be supplied either at the end of the text or in a separate file as requested by the Editor. Ensure you have permission to use any figures you are reproducing from another source. Advice on artwork is available here.

Running heads and **received dates** are not required when submitting a manuscript for review.

If your article is accepted for publication, it will be copy-edited and typeset in the correct style for the journal.

If you have any queries, please contact us at authorqueries@tandf.co.uk, mentioning the full title of the journal you are interested in, or see our Author Services homepage.

Appendix ii

a) **Ethical approval**

------ Forwarded Message

Date: Thu, 24 Jun 2010 09:51:26 +0100

To: <G.Rowse@sheffield.ac.uk>

Subject: Approval of your research proposal

Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals. " has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,

Prof Paschal Sheeran

Chair, DESC

------ End of Forwarded Message

Appendix ii

b) Governance approval

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

6th June 2010

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals
Investigators: Sarah Wonders (DClin Psy Trainee, University of Sheffield); Dr Georgina Rowse, Dr Andrew Thompson (Academic Supervisors, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it, and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

Dr. Rebecca Knowles
Research Tutor

Co. Sarah Wonders, Dr Georgina Rowse, Dr Andrew Thompson

-------- Original Message --------

Subject: Your project in URMS, 128956, has now been authorised

Date: 14 Jul 10 14:50:30

From: noreply@sheffield.ac.uk

To: C.Harrison@sheffield.ac.uk

Project code: 128956

Project title: The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals (Sarah Wonders)

This project has now been checked and authorised by the Research Office. Relevant details can now be transferred to any application forms or documentation. Please note that you should use figures from a project report with the status COSTING APPROVED to ensure you have the finalised figures.

Please note that staff named as Principal Investigator or co-Investigator on the "Investigators" page of the URMS record can access the costing and can, therefore, necessarily see the salaries of staff costed on the grant. Staff salary information is only made available for the purpose of calculating the cost of an application, is strictly confidential and should not be discussed.

Should you have any queries relating to the costs, please contact the URMS helpline on 21450.

GUIDANCE ON URMS PROJECTS AT THE "COSTING APPROVED" STAGE

1. Research applications require Institutional authorisation before submission to the funder. Completed hardcopy applications should be either mailed or dropped off at the Research Office (via the "Research Applications" mailbox) together with any requisite supporting paperwork such as procurement forms or letters of support, and contact details for any queries.

Applications with a full economic cost value less than GBP 750,000 received before noon on any working day will be available for collection by noon the following working day. Applications received after noon will be available by 5pm the following working day. Applications can be returned to departments via mail if required.

Applications with a full economic cost value greater than GBP 750,000 require four days for authorisation due to the availability of the small number of authorised signatories above this amount.

Please note that these timescales also apply to electronic applications.

2. If the Department of Health's "Research Governance Framework" is applicable to the project and external or additional funding is not being sought, e.g. "own account" or student research projects, the project will not be moved to APPLICATION AUTHORISED until the Research Office has received written confirmation of which organisation is the project's Research Governance sponsor.

3. There are several web resources available to staff on the Research Office website, including:

Information regarding University processes for research costing, applications and contracts at: http://www.sheffield.ac.uk/researchoffice/overview/contract.html

Guidance on Research Governance, Clinical Trials & Ethics (and access to the Good Research Practice Standards) at: http://www.sheffield.ac.uk/researchoffice/gov_ethics_grp/governance

General advice and guidance regarding research applications at: http://www.sheffield.ac.uk/researchoffice/advice

********** Research Office New Spring House 231 Glossop Road Sheffield S10 2GW

URMS Helpline: 21450 http://www.sheffield.ac.uk/researchoffice/

Appendix iii

a) Recruitment letter

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

June 2010

Pastoral care and supporting people with their mental health.

Dear Church Leader

I am a Trainee Clinical Psychologist conducting research on spiritual needs and mental health care. I am doing a study specifically focusing on the **experiences of those providing pastoral care** in supporting people in their community with their mental health. This may include ordained clergy, lay leaders or people with designated pastoral responsibilities. The results of this research will be written up as part of a doctoral (DClinPsy) thesis and may also be used for reports and publications.

There are two parts to this study:

- An interview (I will send you more information about this only if you indicate interest).
- A survey (which you can complete online now).

You can choose whether you would like to take part in either, neither or both of these.

(1) First, I would be grateful if you could take a moment to answer some brief screening questions. This should take less than 1 minute of your time. You can access these questions by clicking on this link: (SURVEYMONKEY LINK).

There will be a space for you to provide your contact details if you think you might be interested in taking part in an interview. If so, I will then send you further information about this to help you decide whether you wish to take part.

(2) Next, you will be connected to an online survey. You can complete this even if you do not want to take part in an interview. This should take up to 10 minutes of your time.

Please pass this information on to anyone else you know in a pastoral or church leadership role who may be interested.

If you do not have access to the internet but still wish to take part, you can leave a message for me with the Research Support Officer on 0114 2226650 and I will contact you.

If you have any questions about this study you can contact me by email on pcp08sw@shef.ac.uk or in writing at the address above.

Thank you for taking the time to read this.

With best wishes,

Sarah Wonders
Trainee Clinical Psychologist

Appendix iii

b) Screening questions

Pastoral care and supporting people with mental health difficulties.

Thank you for taking an interest in this study.

The following questions are part of a research project which has received ethical approval from the University of Sheffield. The research forms part of a doctoral (DClinPsy) thesis. Completion of this information is entirely voluntary. If you do not want to answer the questions below, you do not have to. If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Any returned information may be collated and reported in future publications. By submitting this you are consenting for the information you provide to be used in this way. Any information which identifies you will not be used. Data will be stored securely at the University of Sheffield in compliance with the Data Protection Act.

1) Do you regard yourself as a Christian leader or provider of pastoral care within a Christian community? **YES/NO**

2) Do you also work as a hospital chaplain? **YES/NO**

3) Are you aware of any people in your church community with mental health problems? **YES/NO**

4) Have you been involved with supporting individuals in your church community who have difficulties with their mental health? **YES/NO**

5) How much experience have you had **interacting with health services** (e.g. GP's, mental health teams, social workers, mental health nurses, care coordinators, counsellors, psychologists, psychiatrists) in supporting those with mental health problems in your faith community?

NONE **A LITTLE** **A MODERATE AMOUNT** **A LOT**

6) Would you consider participating in a research interview? **YES/NO**

If YES to question 6: Please complete your contact details below so that I can contact you at a later date. These details will be stored confidentially and will **only** be used to contact you. They will not be passed on to any third parties. You will be provided with further information before deciding whether you want to take part.

Name
Address
Email
Phone Number

Thank you.

[Click to submit]

We would now like to invite you to complete a short survey about mental health, your church community and your pastoral role. This should take no longer than 10 minutes of your time. Your answers will remain anonymous.

[Yes please, go to survey] **[No thanks, I do not want to complete the survey]**

Appendix iii

c) Online survey

Pastoral care and supporting people with their mental health[1]

We would like to find out about the experiences of those providing pastoral care within Christian church communities. The following survey asks you some questions about you and your role, your church, your views about mental health, working with health and social care services and support and training. It should take no longer than 10 minutes of your time. The survey is part of a research project which contributes to a doctoral (DClinPsy) thesis. It has received ethical approval from the University of Sheffield. Completion of the survey is voluntary. If you do not want to answer the questions below, you do not have to. You can exit the survey at any time by closing this internet window. The survey is anonymous, therefore once you have submitted your answers, it will not be possible to withdraw your data from the study. All data will be transmitted and stored securely and will be kept at the University of Sheffield. Data will only be accessed by those involved in the research and will be destroyed 5 years after the completion of the study.

Any returned information may be collated and reported (anonymously) in future publications. By submitting your answers you are consenting for the information you provide to be used in this way.

If you have any queries about this study you can contact the researcher at pcp08sw@shef.ac.uk

Thank you for your time

I have read and understand the information above [Y/N]
I understand that my participation is voluntary and that I do not have to complete the survey if I do not want to [Y/N]
I give consent to take part in this survey [Y/N]

About you.....

1. **Gender** [M/F]
2. **Age** [18-25, 26-35, 36-45, 46-55, 56-65, 66-75, 76+]
3. **First part of your church postcode only (e.g. S2, S17, NG5)** [Open text box – limit to 4 characters if possible]
4. **Would you regard your church as:** [Urban, Suburban, Rural]
5. **Church denomination** [Anglican, Methodist, Catholic, Baptist, Pentecostal, United Reformed, Salvation Army, Independent, Other (please state)]
6. **What is the estimated size of your church community (based on average weekly attendance)?** [Less than 50, 50-199, 200-499, 500-1000, More than 1000]
7. **How would you describe your current role in relation to the pastoral care you provide (e.g. youth worker, pastoral advisor, church leader)** [Open question]
8. **How many years of experience do you have overall in pastoral care role(s)** [0-5, 6-15, 16-25, 26-35, 35+]

[1] Please note this questionnaire was formatted appropriately when created on surveymonkey. This is an example of the content of the survey with response categories provided in brackets.

9. **Do you have additional qualifications in any of the following**: [Nursing, Counselling, Social Work, Medicine, Psychology, Other Health Profession?]
10. **Have you ever experienced mental health difficulties of your own?** [Y/N/prefer not to answer]
11. **Have your own experiences of mental health difficulties helped you in the care you provide to those in your community?**
    [N/A,They are irrelevant/unhelpful, Helpful if kept to myself, Helpful if shared with others]

We would be grateful if you could answer the following questions in relation to your role over the **past 5 years**.

<u>About your church and supporting people with their mental health....</u>

12. **Are you aware of any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
13. **Have you been involved in supporting any people within your church who have been affected by the following (please select all that apply):**
    [Anxiety, Depression, Psychosis/Schizophrenia, Phobias, Addictions (drugs/alcohol), Trauma, Learning disabilities, Dementia, Bereavement, Other (PLEASE SPECIFY)]
14. **How often do you discuss mental health issues with those in your pastoral care?**
[Never, very occasionally, occasionally, often, always]
15. **In the past 5 years, how many times have you been involved in *supporting* someone in your community with their mental health?**
    [Never, 1-5, 6-10, 11-15, 16-20, more than 20 times]
16. **What does the support you offer involve? [Open question]**
17. **In your role, are there activities that you are involved with that promote peoples' mental health and wellbeing?**
    [Yes (please specify-text box)/No]
18. **Does your church actively provide services (e.g. groups, courses) which specifically have a role in promoting or maintaining peoples' mental health?**
    [Yes (please specify-text box), No]

<u>Your views about mental health and wellbeing.....</u>

Please indicate your agreement with the following statements:

19. **Mental health is a topic which is relevant for the church**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
20. **I feel I have a good understanding of these issues**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
21. **I am confident in my ability to *notice* if somebody is experiencing difficulties in this area**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
22. **I am confident in supporting somebody with their mental health**

[Strongly agree – agree – unsure - disagree – strongly disagree]

23. **It is not part of my role to help support people with their mental health**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
24. **I usually know when somebody needs more help than I am able to offer (e.g. needs help from health services)**
    [Strongly agree – agree – unsure - disagree – strongly disagree]
25. **It is difficult to distinguish between spiritual difficulties and mental health difficulties**
    [Strongly agree – agree – unsure - disagree – strongly disagree]

<u>Working with health and social care services.....</u>

26. **In the past 5 years, how often have you referred someone in your care to a health professional?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If never, please go to question [number])
27. **Who have you referred people to? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, MH chaplain, Counsellor, Other (please specify)]
28. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
29. **In the past 5 years, how often have you contacted a health professional for joint-working or advice?**
    [Never, once, 2-4 times, 5-7 times, 8 times or more]
    (If 'never' please go to Question [number])
30. **Who have you contacted? (Please select all that apply)**
    [GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor, Other (please specify)]
31. **Which organisation were the health professionals working for? (please select all that apply)**
    [NHS, private organisation, religious organisation, charitable organisation]
32. **Why did you make the referral or seek consultation?**
    [Open Q – text box]
33. **If you have never or rarely made a referral or sought consultation, what are the reasons for this?**
    [Not necessary, didn't think of it, didn't know how to refer, worried that health professionals won't understand person's faith, *patient did not want me to, it was not my responsibility, don't know when this is necessary, other (PLEASE SPECIFY)]*
34. **In what circumstances do you think that it would it be helpful to refer to a mental health professional? (Please select all which apply)**
    [Only if requested by person, when person is risk to self/others, person experiencing irrational thoughts/fears, when family/friends worried, when person thinks they are possessed, when experiencing religious delusions, other (please specify)]
35. **Do you know who your local chaplain is*? [Y/N]***
36. **In the past 5 years, has a health professional ever referred someone to you, or consulted you for advice in relation to a patient?**

[Never, once, 2-4 times, 5-7 times, 8 times or more]

37. **What was the profession of the person who contacted you? (Please select all that apply)**
    [N/A, GP, NHS counsellor, Social Worker, Nurse, Psychologist, Psychiatrist, mental health chaplain, Counsellor (NHS), Counsellor (Private), Counsellor (Religious), Other (PLEASE SPECIFY)]
38. **Generally, has your experience of working with health professionals been *helpful* in supporting member(s) of your community?**
    [Very much, mostly, a little bit, not at all]
39. **How would you rate the *communication* which you have received from the health professionals?**
    [Very poor, poor, adequate, good, very good]
40. **Generally, how much did you feel you had a shared understanding with the health professionals of the person's difficulties**
    [Very much, mostly, a little bit, not at all]
41. **How much did you feel you agreed about the best way to support the person and help manage their difficulties?**
    [Very much, mostly, a little bit, not at all]
42. **Did you receive any feedback from the health service staff, keeping you informed of the situation or of their actions?**
    [yes/no]
43. **Were there opportunites to work with or alongside the health professional(s) to support the person**
    [yes/no]
44. **How much did you feel that your role and opinion was valued by the health professional?**
    [Very much, mostly, a little bit, not at all]
45. **How much did you feel that your role and opinion was valued by the person in your community?**
    [Very much, mostly, a little bit, not at all]

<u>About support for you.....</u>

46. **Did you receive any training in mental health before qualifying/starting in your role?**
    [None, very little, adequate, a lot]
47. **Have you received any training in mental health since qualifying/starting in your role?**
    [None, very little, adequate, a lot]
48. **Do you feel that you and your wider church community are able to support those with mental health difficulties?**
    [Always, most of the time, sometimes, rarely, never]
49. **What kind of training or information about mental health care would you find most helpful now?**
    [None needed, promoting mental health/prevention of difficulties, warning signs/detection of difficulties, information about mental health difficulties and how to manage them , how to discern between mental and spiritual ill health, referral routes/confidentiality/data protection, knowing when to refer, other (PLEASE SPECIFY)]

Additional comments.....

Finally, is there anything else you would like to say? Are there any areas that you think have been overlooked? Is there anything else that you think it is important for researchers to consider?

[OPEN RESPONSE]

[FINISH AND SUBMIT MY ANSWERS!]

Thank you for taking the time to complete this survey.

If you have any questions regarding this study, please contact the researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Appendix iii

d) Information sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

INFORMATION SHEET

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take some time to decide whether or not you would like to take part. You can discuss this with others if you wish. Please ask if there is anything that is unclear or if you would like more information.

What is the purpose of the project?
We know that many people experience mental health difficulties at some point in their life. During times of distress people often turn to people they trust for help and support. They may also seek help from health services. Recent government guidelines recommend that effective links should be made between faith groups and health services.

This study aims to explore community-based Christian leaders'[2] *experiences* of providing pastoral support to members of their community with mental health needs. We do not know very much about this yet and would like to learn more. This research project forms part of a Doctoral DClinPsy thesis due for submission in July 2011.

Why have I been chosen?
You have indicated that you have some experience supporting people in your community with their mental health, and interacting with health care services. We are interested in hearing about your experiences. You have been selected from local Christian leaders who have experience in these areas and expressed an interest in participating in research.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You can still

[2] This includes ordained clergy, lay leaders and those with designated responsibilities in pastoral care roles.

withdraw from the research at any time before, during or up to 2 weeks after the interview. You do not have to give a reason.

What will happen to me if I take part?
If you decide to take part, you will be visited by a researcher at a location which is convenient to you. The interview will need to take place in a quiet/confidential environment. If this is not possible at your place of work or residence, arrangements may be made to conduct the interviews at the university site.
You will go through this information sheet with the researcher and be given the opportunity to ask questions. If you are still happy to take part, you will be asked to sign a consent form.
You will then be interviewed by the researcher. This will be a series of open questions (rather than a structured questionnaire) and will require you to speak openly about your experiences. Length of individual interviews will vary, but we estimate that the interview will last around 1 hour. Interviews will be recorded using audio equipment.
You will also be asked for some background information about yourself and your church (such as age, ethnicity, training/occupational background, church denomination/affiliation, size of congregation).

What do I have to do?
You will be asked to be present at an agreed time and place to take part in the interview with the researcher. You will need to be available for the full length of the interview. You will also need to allow some time to go through this information sheet and complete the background data.

Will my taking part in this project be kept confidential?
All the information that we collect about you during the course of the research will be confidential and will be stored securely at the University of Sheffield in accordance with the Data Protection Act. Data will be kept for 5 years following completion of the study and then destroyed.

Only those directly involved in the research, and University approved transcribers will have access to this. Transcribers sign a statement of confidentiality before beginning transcription and are required to discontinue transcription if the person involved in the interview is known to them.

Extracts from the interview may be used in reports and publications, however, every effort will be made to ensure you are not identifiable in these. Names (e.g. of individuals or churches) will not be used, or will be replaced with pseudonyms.

However, in the event that anything you say leads us to be concerned about your own safety, or the safety of others, we have a duty to act on this. Similarly we cannot maintain confidentiality if we are required to pass on information for legal reasons.

What are the possible disadvantages and risks of taking part?
Although we do not anticipate any undue risks for those taking part there are some things to consider.

The interview will take up some of your time. Neither the researcher nor yourself can predict the exact details of the discussion during the interview. There is a chance that you may think back over what you talked about and not be comfortable with this. If this is the case you can contact the researcher up to 2 weeks after the interview and ask to withdraw from the study. In the unlikely event that the interview causes you any distress, you can ask to stop the interview. We would advise you to seek support from your colleagues or visit your GP.

During the interview it is likely that you will talk about your experiences working with other people. We would ask you to consider your own codes of confidentiality whilst doing this and avoid mentioning names or identifiable information. As mentioned above, if any names *are* mentioned during the interview, these will not be used, or will be replaced with pseudonyms.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for individuals participating in the project, it is hoped that this work will help us to understand the experiences of those in pastoral care roles who support people with their mental health, and have experience working with health services. We hope that this will help inform future practice in finding approaches which support peoples' spiritual and mental health needs.

What happens if the research study stops earlier than expected?
If this is the case the reason(s) should be explained to you.

Will I be recorded, and how will the recorded media be used?
The interviews will be recorded using audio tape. The audio recordings of the research interview will be transcribed into written form and used for analysis. No other use will be made of them without your written permission, and no one outside of the project will be allowed access to the original recordings.

The tapes will be stored confidentially at the University of Sheffield for as long as required. They will be disposed of after the research has been completed and they are no longer required for auditing purposes.

What will happen to the results of the research project?
The results of the overall project will be written up and submitted as a DClinPsy research thesis. Results may also be published as reports or journal articles. As mentioned above, identifiable information will not be used in any reports/publications. A copy of any publications can be obtained upon request from the researcher.

Who is organising and funding the research?
This research is funded by the NHS and the Clinical Psychology Unit at the University of Sheffield.

Expenses and payments.
We regret that we do not have sufficient funding to compensate you for any expenses incurred in participating (e.g. travel or compensation for your time) and your participation would be entirely voluntary.

Who has ethically reviewed the project?
This project has received ethical approval by the Department of Psychology's Ethics Review Committee at the University of Sheffield.

What if I want to make a complaint?
Should you wish to raise a complaint about the conduct of this research you should contact the Research Supervisor for this project in the first instance:

Dr. Andrew Thompson
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: A.R.Thompson@sheffield.ac.uk

Telephone: 0114 2226637

If you wish to make a formal complaint about any aspect of the study, please contact the University Registrar.

Dr Phillip Harvey
Registrar and Secretary's Office
University of Sheffield
Firth Court
Western Bank
Sheffield, S10 2TN

Contact for further information
For information relating to this study please contact the primary researcher:

Sarah Wonders
Clinical Psychology Unit
Department of Psychology
Western Bank
Sheffield, S10 2TN
Email: pcp08sw@sheffield.ac.uk

Telephone messages can be left with the Research Support Officer on: 0114 2226650.
Please note: the Research Support Officer cannot answer enquiries about the project but can pass on a message to Sarah Wonders (the researcher) who will call you back.

Thank you for taking the time to read this.

Appendix iii

e) Consent form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClinPsy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

CONSENT FORM

The experiences of those providing pastoral care in the Christian church community: Supporting people with their mental health and interacting with health professionals.

Name of Researcher: Sarah Wonders

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated ……. for the above project and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw before, during, or up to 2 weeks after the interview without giving any reason. ☐

   (Should you choose to withdraw, you can do this by writing to Sarah Wonders at Clinical Psychology Unit, Department of Psychology, Western Bank, Sheffield, S10 2TN. Or by email pcp08sw@shef.ac.uk)

3. I understand that the interview will be recorded using audio equipment. I give permission for the interview to be recorded in this way. ☐

4. I understand that an approved transcriber who has signed a confidentiality agreement will also listen to the tapes to type them into written form. ☐

5. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my responses. ☐

6. I understand that the results of the research project may be published, and that this may include anonymised quotes from my interview. ☐

7. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

(*if different from lead researcher*) *To be signed and dated in presence of the participant*

_____	_____	_____
Lead Researcher	Date	Signature

To be signed and dated in presence of the participant

Thank you for agreeing to take part.

Appendix iii

f) Topic guide

[Introduce self and study, info sheets and consent]

1) **To begin with, I wonder if you could tell me a little bit about your role in pastoral care of your church community?**

    - What do you view as your role?
    - How would you define this role?
    - Can you give me some examples of the things you do?
        - Is there anything else you do which you have not mentioned?
    - What do you view as outside of your role?
    - How do you think other people view your role?
    - How much of your time/day/week does it take up?

2) **Can you talk a bit about your experiences supporting people with their mental health?**

    - In your role, what sorts of words do you use when talking about peoples' mental health? Are there any words or phrases that you would avoid?
    - What would be your understanding of mental health?
    - Without breaking confidentiality, or naming any individuals, can you think of an example of someone who has experienced problems with their mental health?
        - Tell me a bit about what happened with that person?
        - How did you become aware of their difficulties?
        - Describe your interactions with each other?
        - What was your understanding of the issues they were facing?
    - Have you had any other experiences before/since then?
        - How was this different? How was it similar?
    - How often do you encounter people with mental health difficulties?
        - Why do you think this is the case?
    - How do you think your church community interacts with/experiences those with mental health difficulties?

- How do those with mental health problems interact with/experience the church community?

- What are the main issues which arise when supporting people with people with their mental health?
- Are there other things which you or your church do to support people with their mental health?

3) **Could you tell me about your experiences working alongside or interacting with health professionals or health services in relation to the mental health of those in your community?**

- Can you think of a time when you have had contact with health services/professionals?
  - How did this come about?
  - What happened?
  - Who contacted who?
  - How did you feel about it?
- Was anything helpful about this? Was anything unhelpful/difficult?
- What was communication like? Did you have any similar or different points of view?

4) **Tell me about the outcome or impact of this work?**

- Did your experience have an effect on you in anyway?
  - How do you think the experience affected the person you were supporting?
  - Did you notice any impact for the health professionals?
- How did you feel about it at the time? How do you feel about it now?
- Have you learned anything from your experiences?
- Would you hope anything to be similar or different in the future?
- Is there anything you would find helpful in supporting those with mental health needs? Is there anything that you would find unhelpful?

Well, that's the end of the questions from me, but before we finish, I wondered if there's anything you wish I'd asked you more about? Is there anything you think I should have asked you that I haven't? Is there anything else you would like to say?

[Complete demographic sheet]
[Debrief. Ascertain interest in findings. Inform of likely timings and contact details.]

Appendix iii

g) Demographics sheet

Participant Demographics

Gender: Male / Female

Age:

Ethnicity:

Ordained/Lay Leader?

Years of experience in Church Ministry:

Chaplaincy experience?

Occupational history:

Highest Educational Qualification:

Personal Denomination/Church Affiliation:

Additional info of note:

Church Demographics

Size (average weekly attendance):

Catchment: Rural Urban Suburban

Demographic of congregation (age, ethnicity, SES):

Denomination/Affiliation:

How would you describe your church:

Additional info of note:

Appendix iii

h) **Extracts from analysis**

1. **Extract from coded transcript**

Theme	Text	Initial notes/coding
"Managed availability" Maintaining health of clergy and clients Christ as role model	Erm, and, but even that's a managed availability in a sense. I think it's also very destructive for the priest because it tends to, it tends to feed in to our sort of, well, counter-transference I suppose if one wants to use that sort of language, of...actually..it often tends to be an identification with, self-identification with Christ in an unhealthy way that I *ought* to be all loving, always available, always for people and therefore I can't draw any boundaries because Jesus didn't. Of course that's false because he did (small laugh), er, in fact, erm, and it's very interesting to read the Gospels with the view to exploring the question of availability, unavailability and boundary for Christ because actually there's a surprising amount in it, erm, but it, it doesn't help the client and it doesn't, it doesn't assist the priest. **R:** So..	Importance of sustaining health for client and clergy 'Meeting' me in my professional role? Christ as a role model Refer to scripture for guidance/wisdom NB. Part of his role is pastoral care of his colleagues so is this why there is a big focus on protecting professional boundaries??

Clergy-led/in charge Importance of multiple boundaries: Time, frequency, space Significance of boundaries Clergy make offering to person based on perceived need (adapting to need)	**P:** and so, yeah, I could say there's, if we look at it there's b- boundaries of time that, I make a certain amount of time available and then I will pace when I'm available in the future. I much prefer offering pastoral care, if I'm seeing somebody more than twice I would typically be seeing them once every, except during a moment of crisis, I'd be seeing them every four or six weeks so it's really quite occasional. Erm..I'd, I'd set a boundary of time and how long I would see people..I would set a boundary of space in as much as I'd almost always meet in a, erm, safe space where other people were around or in a quiet place where I'm almost observed in the cathedral and you see that [knocks] even the table here is carefully designed to, to, to keep boundaries and because there's such, has been such poor practice in boundaries of space and touching..people, erm, I..*never*..touch somebody. Erm..I very occasionally when somebody's extremely distressed I'll offer an open, a palm..an open hand..and then it's for the person to decide whether	Time management "I" = Maintaining control. Specified. Led by own model of practice. LOTS of attention and time given to emphasising boundaries! Important. Avoid isolation? Vulnerability/fear? Recognition of historical issues in church influencing current practice

Choice remains with client	they wish to hold my hand but they're holding it, and often with people who are dying or who are in enormous pain, offering a hand like that and just remaining silent with a person is the most effective engagement but even with somebody who's dying in, it's always, it's almost always possible for them to decide..to initiate touch	Individual autonomy Offering Simplicity in approach Client-led

Appendix iii

h) Extracts from analysis

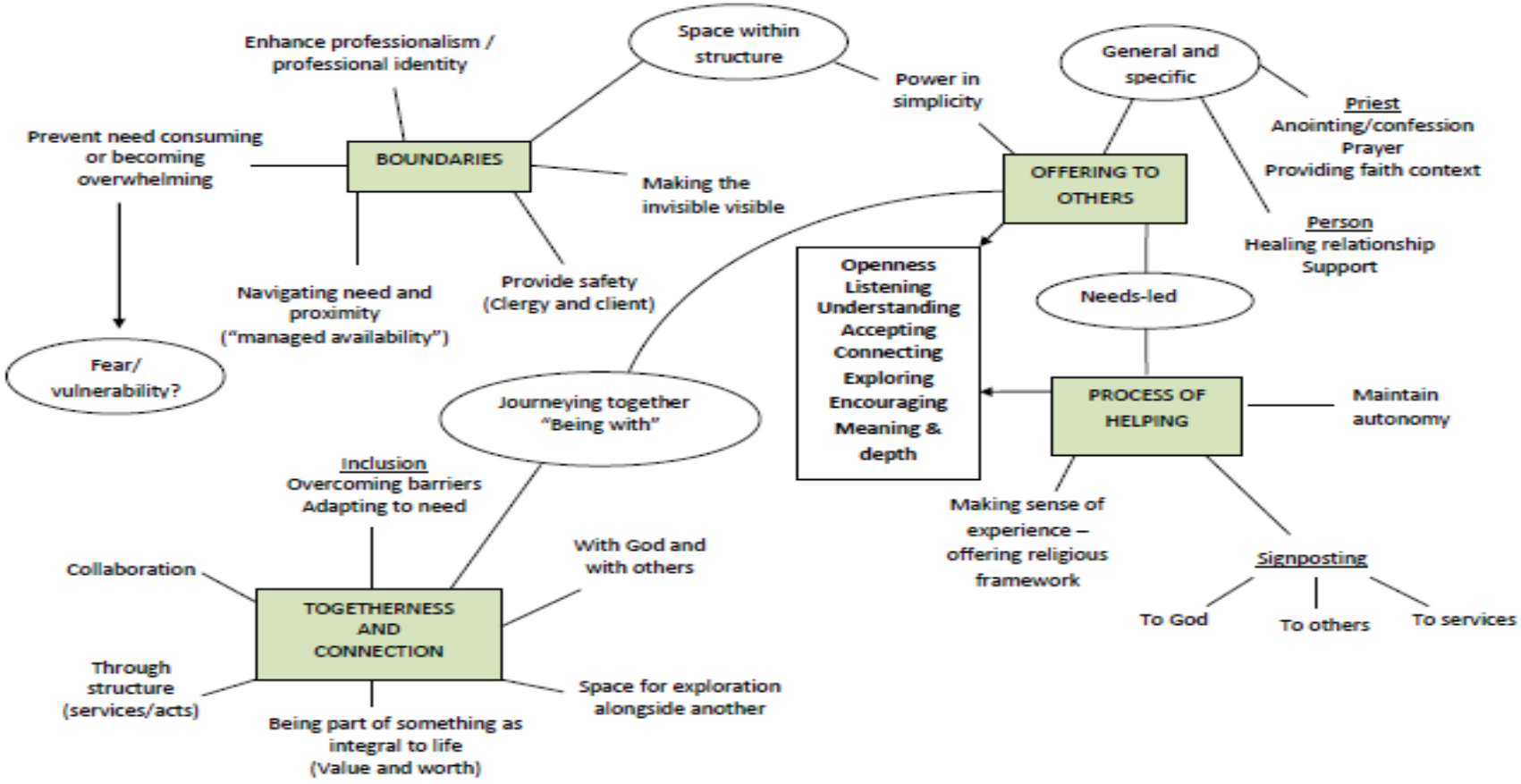
2. Extract of list of themes

Theme	Page	Line ref
Role located within hierarchy	1	4-16
Seniority and uniqueness		6, 12,
From parliament/policy to people		11-14
Pastoral role at multiple levels of system		6-14
Extensiveness of role, held within structure	2	16-19
Giving of self, receiving of others "witness"		24-28
OFFERING - safety, thought, hearing, meaning		26-28
Opportunity for exploration/meaning		27-28
Importance of clear understanding	3	37
Depth of interaction - seeing and hearing beyond the immediate		37-38
Strong, clear structure and boundaries in place (imposed?) around *collaborative* exploration		40-45
Moving forward as part of process	4	47
People seek out clergy		49
"Formula"/structure allows clergy to maintain control of interaction		50-56
Boundaries infused through interactions		53-56
Listening as a process of picking apart("tease out"), checking understanding and bringing together ("summarising")		58-61

Appendix iii

h) Extracts from analysis

3. Exemplar map


Space within structure
Enhance professionalism / professional identity
Power in simplicity
General and specific
Priest
Anointing/confession
Prayer
Providing faith context
Prevent need consuming or becoming overwhelming
BOUNDARIES
Making the invisible visible
OFFERING TO OTHERS
Person
Healing relationship
Support
Navigating need and proximity ("managed availability")
Provide safety (Clergy and client)
Openness
Listening
Understanding
Accepting
Connecting
Exploring
Encouraging
Meaning & depth
Needs-led
Fear/ vulnerability?
Journeying together "Being with"
PROCESS OF HELPING
Maintain autonomy
Inclusion
Overcoming barriers
Adapting to need
Making sense of experience – offering religious framework
Signposting
Collaboration
With God and with others
TOGETHERNESS AND CONNECTION
To God
To others
To services
Through structure (services/acts)
Space for exploration alongside another
Being part of something as integral to life (Value and worth)

Appendix iii

i) **Ordination liturgy**

Extract from the Church of England liturgy for the ordination of priests. Retrieved from:
http://www.churchofengland.org/prayer-worship/worship/texts/ordinal/priests.aspx

The Declarations

Bishop: Priests are called to be servants and shepherds among the people to whom they are sent. With their Bishop and fellow ministers, they are to proclaim the word of the Lord and to watch for the signs of God's new creation. They are to be messengers, watchmen and stewards of the Lord; they are to teach and to admonish, to feed and provide for his family, to search for his children in the wilderness of this world's temptations, and to guide them through its confusions, that they may be saved through Christ for ever. Formed by the word, they are to call their hearers to repentance and to declare in Christ's name the absolution and forgiveness of their sins.

With all God's people, they are to tell the story of God's love. They are to baptize new disciples in the name of the Father, and of the Son, and of the Holy Spirit, and to walk with them in the way of Christ, nurturing them in the faith. They are to unfold the Scriptures, to preach the word in season and out of season, and to declare the mighty acts of God. They are to preside at the Lord's table and lead his people in worship, offering with them a spiritual sacrifice of praise and thanksgiving. They are to bless the people in God's name. They are to resist evil, support the weak, defend the poor, and intercede for all in need. They are to minister to the sick and prepare the dying for their death. Guided by the Spirit, they are to discern and foster the gifts of all God's people, that the whole Church may be built up in unity and faith.

The bishop addresses the ordinands

We trust that long ago you began to weigh and ponder all this, and that you are fully determined, by the grace of God, to devote yourself wholly to his service, so that as you daily follow the rule and teaching of our Lord and grow into his likeness, God may sanctify the lives of all with whom you have to do.