Gods and gurdwaras: the Spiritual Care Programme at the Birmingham and Solihull Mental Health Foundation NHS Trust

Madeleine Parkes & Peter Gilbert

Gods and gurdwaras: the Spiritual Care Programme at the Birmingham and Solihull Mental Health Foundation NHS Trust

Madeleine Parkes* and Peter Gilbert

Birmingham and Solihull Mental Health Foundation NHS Trust and Staffordshire University, UK

With Great Britain being seen as a largely secular society, it would be easy to discount the influence of religious belief and faith communities in society in general, and mental health in particular. But most rural communities still have a parish church, which provides a focal point for a range of activities, not necessarily religious; and in the big cities, especially where there are a range of ethnic groups and cultures, places of worship provide prominent landmarks. In the field of mental health, many service-users say that their spiritual beliefs (religious or otherwise) form an important part of their essential life-force and is a key to their recovery. Where there are prominent faith communities, it is vital that mental health services pay due attention to working productively with them towards a mutual understanding and partnership.

Keywords: faith; consumerism; Birmingham; society; empathy; community

"Is there anybody there?"

A few weeks before the feast of Christmas in 2009, the Archbishop of Canterbury, Dr Rowan Williams accused the Government of treating religious faith as though it was a problem, an eccentricity "practised by oddities, foreigners and minorities." The effect, continued Dr Williams is to "de-normalise faith, to intensify the perception that faith is not part of our bloodstream. And, you know, in great swathes of the country that's how it is" (Beckford & Pitcher, 2009). The former Bishop of Urban Life, the Right Reverend Stephen Lowe echoed Dr William's thoughts when he added that:

> What seems to be forgotten is the contribution of religion in the mainstream for social action. It's quite clear that within the Government and the Opposition there are people of faith. The problem is that somehow the connection between what they see as their private faith is allowed to marginalise the significance of the contribution of faith communities to the life of this nation.

If faith and faith communities are seen as marginal it is ironic to drive through Birmingham and find on every side of the road as one passes through, a gurdwara, parish church, mosque, temple, Pentecostal church, gospel hall or synagogue. These buildings are often not only places of worship, but also foci of community activity and social action.

*Corresponding author. Email: Madeleine.Parkes@bsmhft.nhs.uk

In a recent event involving chaplains of different faiths from across the British armed forces, held in the Nishkam community centre attached to the Sikh Gurdwara in Soho Road, Birmingham, a Christian chaplain joked that: "while Jesus fed the five thousand, the Gurdwara feeds thirty thousand a week!" (through the "Langar" meals service, which is open to people of all faiths and none).

Europe, as the seat of the Enlightenment, is in many ways profoundly secular, though as Dinham and Lowndes point out, one has be cautious about the concept of "secularisation," as the original Latin use of *saeculum* ("age") considered "the contrast between the immanency and time-boundedness of the world with the atemporality and eternal nature of the heavenly" (Dinham & Lowndes, 2009, p. 3).

It is often remarked that shopping is the new religion, and that retail arcades such as the Trafford Centre in Manchester are the new cathedrals. In a leader article on the 2008/2009 credit crunch, *The Guardian* newspaper commented that:

> To shop or not to shop, that is the question. For Gordon Brown, spending is the route to salvation...Just about everyone now seems to have agreed with Madonna that we live in a material world.

And again:

> "The British economy has long been structured around consumerism, and Mr Brown now judges that only consumerism can revive it." In truth, however, Britain's acquisitive culture is yet another symptom of inequality, which generates so much anxiety about status. Anyone truly concerned for the health of society must put the levelling of wealth and incomes on their shopping list. (*The Guardian*, 2009)

Even if we do live in largely "material world," perhaps there is some reason to think that we should pay more attention to faith and faith communities. The twentieth century saw the rise and fall of the monolithic ideologies such as Nazism and Communism so ably outlined in Michael Burleigh's *Earthly Powers* and *Sacred Causes* (Burleigh, 2005, 2006). Freedom from these oppressive social models, then globalisation, and increasing access to material goods, was meant to lead to increasing indices of happiness, but instead often seems to have led to atomisation, isolation and increasing levels of mental distress (see Atherton, Graham, & Steadman, 2010; McMahon, 2006). In fact Lynne Friedli (2009) in her research for the World Health Organisation (Europe) found that material inequality was causing increasing levels of mental distress. Even ostensibly successful people are suffering from the current pressures. South Korean Daul Kim sadly committed suicide in the autumn of 2009. On her blog dated 15 October, the model had written:

> Freedom comes with such a cost. But is it even freedom? One could get numb living like this...decadent nights to make up for losses. But this endless loneliness. There must be something wrong from the core. (Usborne, 2009, p. 14)

In their Christmas (2009) messages, the Archbishop of Canterbury, and the Roman Catholic Archbishop of Westminster (Vincent Nichols) both commented on the stresses modern society placed on young children. As Williams put is, there is pressure on children to become: "Active little consumers and performers." The message being sent out to children today is:

> We shall test you relentlessly in schools, we shall bombard you with advertising, often highly sexualised advertising, we shall worry you about your prospects and skills from the word go. We shall do all we can to make childhood a brief and rather regrettable stage on the way to the real thing, which is 'independence', turning you into a useful cog in the social machine that won't need too much maintenance.

Archbishop Nichols came in from the perspective of human beings' need for identity: While we long for a sense of community. Many young people turn to gangs and gang violence to bolster their weakened sense of identity (See Gledhill, 2009).

In research terms, these comments are underpinned by economist Richard Layard and psychologist Judy Dunn's report for The Children's Society: *A Good Childhood: Searching for values in a competitive age*, where they opined that "There is one common theme that links all these problems: excessive individualism" (Layard & Dunn, 2009, p. 4).

The second reason for thinking we should pay more attention to something other than purely the "material world" is set out in a number of studies, perhaps the most well known being Paul Heelas and Linda Woodhead's *The Spiritual Revolution* (2005) and physical scientist, David Hay's research in Nottingham and his publication: *Something There: The biology of the human spirit* (Hay, 2006). The essence of Hay's research where he has asked people from many walks of life about their beliefs, comes in the title: *Something There*. Hay quotes the Roman Catholic theologian Karl Rahner, as saying:

> And even if this term (God) were ever to be forgotten, even then, in the decisive moments of our lives, we should still be constantly encompassed by this nameless mystery of our existence...Even supposing that those realities which we call religion...were totally to disappear...The transcendality inherent in human life is such that we would still reach out towards that mystery that lies outside our control. (Hay, 2006, p. 122)

Hay points to an increase in the frequency of reported spiritual experiences between 1987 and 2000. Aspects reported are around the synchronicity or patterning of events; an awareness of a divine presence; a feeling that prayers have been answered; the sensation of a sacred presence in nature; awareness of the dead; and an awareness of an evil presence (see also Tart, 2009).

Both these books make fascinating reading, but one almost doesn't need to look at the research to understand what is happening. Stand in any bookshop or outside any cinema and what becomes immediately clear is that there is a deep and probably increasing interest in what one might broadly call the super-natural. Most cinemas will have a love story, a comedy, an adventure film, a science fiction film and a story about the supernatural. The latter might be something like the recent *Paranormal*, apparently based on a true story. The books by J.K. Rowling, J.R.R. Tolkien, Philip Pulman and C.S. Lewis have all been popular cinematic successes, whether they seem to be sympathetic to religious experience, such as C.S. Lewis' *The Narnia* stories or, alternatively, Philip Pulman's *His Dark Materials*, which unfortunately only made one film, before apparently objections from the religious right in the United States sabotaged the other two parts of the trilogy.

The recent success of the *Twilight* series of books about vampires, also being turned into films, may be about to be superseded by a fascination with angels: both "good" and "bad" (see Measure, 2009). On a slightly more intellectual level, the theologian, David Albert Jones, is about to publish his book on angels. As Jones describes them:

> Angels are *liminal* figures at the *threshold* between the visible and the invisible world. The elusive character of angels helps explain why they remain popular in an age that finds faith difficult. Iris Murdoch described this age as a 'time of angels'. (Jones, 2009, and see Jones, 2010; our emphasis)

Of course all of this may purely be to do with the fact that human beings seem to be nourished by stories. We are all sons and daughters of Homer, and right back to the dawn of time human beings seem to have sat around campfires telling stories to each other. As Terry Pratchett, sometimes described as the modern Charles Dickens, an atheist who

always seems to bring God into his stories, wrote: "Humans need fantasy to be human. To seek a place where the falling angel meets the rising ape" (a reference to Augustine of Hippo's thought) (Pratchett, 1996).

A third aspect that leads on from the second is the issue of the bond which ties human beings together for a common purpose. British Prime Minister Margaret Thatcher famously said: "There is no such thing as society, there are individuals and families and nothing else." While we might not wish to go as far as Rousseau's concept of "the general will," there needs to be some idea as to how individuals and families and other groups can join together for what might best be termed "the common good."

Both an overemphasis on the individual or of society can have destructive consequences. Aristotle and Plato both mused on this, and the Greeks always had Aristophanes to poke fun at those going to extremes. Michael Burleigh, in his two books, *Looking Back to French Revolution and Forward to the Present Day*, speaks of the dangers of "political religions" and quotes Italian thinker Luigi Sturzo who referred to the Jacobin phase of the French Revolution as "the abusive exploitation of the human religious sentiment." (Burleigh, 2006, p. xi)

Simone Weil, writing shortly after the end of the Second World War and the apotheosis of such abusive exploitation, speaks of "the needs of the soul";

> To be *rooted* is perhaps the most important and least recognised need of the human soul. It is one of the hardest to define. A human being has roots by virtue of his (sic) real, active and natural participation in the life of the community which preserves in living shape certain particular treasures of the past and certain particular expectations of the future. (Weil, 1949/2002, p. 43, our emphasis)

Writing about "love as deed," Chief Rabbi, Jonathan Sacks describes a community as an entity "*where they know your name* and where they *miss you when you are not there*. Community is society with a human face" (Sacks, 2005, p. 54). Sacks goes on to say that society is for what we cannot do purely on our own.

Pope Benedict XVI in his encyclical letter, which partly addressed the crisis brought on by "casino capitalism," writes in *Caritas in Veritate* (2009):

> Another important consideration is the common good. To love someone is to desire that person's good and to take effective steps to secure it. Besides the good of the individual, there is a good that is linked to living in society: the common good. It is the good of 'all of us', made up of individuals, families, intermediate groups who together constitute society ... to desire *the common good* and strive towards it *is a requirement of justice and charity*. (p. 7)

Orthodox religious leaders recognise that there is a largely positive creative tension between the civil state and the faith communities. Where there are issues, for instance, around the intrinsic value of human life, then religious communities can play a vital part in questioning a prevailing trend. Theocracies, from Savonarola's Florence to modern-day Iran, have usually been repressive; and the "political religions" of the twentieth century were partly so disastrous because there was no room for any critique. For individuals too it is vital to have a sense of identity and rootedness, but also to have that identity made up of several facets. An overemphasis on one aspect of identity can lead to fanaticism (see Sen, 2006).

The greatest historian of the French Revolution, Alexis de Tocqueville was appalled by the icy uniformity imposed by politicians such as Robespierre; but he was similarly unhappy in his visit to America to find an individualism which wrapped each person within the cavity of their own heart.

The last point is that it is clear that in many ways Europe is, in Grace Davie's phrase "the exceptional case" (Davie, 2002). Economists John Micklethwait and Adrian Wooldridge (2009) argue that "God is back" and chart a considerable surge of religious belief and practice across the world. They quote Peter Berger, one of the foremost sociologists of religion as stating recently that: "We made a category mistake. We thought that the relationship was between modernisation and secularisation. In fact it was between modernisation and pluralism." Increasingly people are making a choice about what they believe, and that quite often is for a religious faith (Mickelthwait & Wooldridge, 2009). Closer to home the recent Royal College of Psychiatrist's book on *Spirituality and Psychiatry* (Cook, Powell, & Sims, 2009) referred to the 2001 UK census, which demonstrates a very high proportion, 76.8% of the population, affiliating to a specific religious faith. This may be much to do with a desire for identity, however loose, than actual religious allegiance. Work with second-generation Pakistani Muslims living in Britain show that part of their adherence to Islam is to do with religious faith, but it is also to do with their identity and wishing to state that they are not purely secular.

Beliefs may be increasingly varied and in some cases quite fragmented, but it is also part of a vibrant civic life, and faith communities can ensure that there is some measure of social cohesion, often in areas that were previously fragmented, and a vigorous debate about the values which drive modern life.

Empathy – human and divine

It has been said that there are a number of "languages of love," and that as in speech, the languages are not always easily translatable one to another. Some of the separate, though sometimes interconnected languages are: touch, gifts, time, words and acts of service.

One of Graham Greene's characters in *The Heart of the Matter*, muses that: "When he (Scobie) was young, he had thought love had something to do with understanding, but with age he knew that no human being understood another. Love was the wish to understand . . ." (Greene, 1948/2001, p. 253).

In 2009 the Birmingham and Solihull Mental Health Trust (henceforth referred to as BSMHFT/the Trust) were working with a faith community whose members were made up mainly of Asians coming from the Indian subcontinent and East Africa. The community had taken the courageous decision to look at issues of mental health and illness head on, by setting up an open seminar in their community centre. The "strategic permission," which this allowed meant that a wide range of people were able to come and discuss these issues in a place of safety, with no fear of the stigma that can be a major problem in Asian communities. At the lunch break a young woman hurried into the seminar room, and asked to speak to one of the presenters from the Trust, and a member of the faith community. She desperately needed to talk, and had been freed to do so by the "permission" given by the community. She was a single parent who felt abandoned by life. An intelligent and articulate young woman, she had begun to lose faith and hope. She was clearly depressed – though with the energy to take this chance of reconnection – and had contemplated suicide. What was keeping her going was the love of her young child.

What she told her interlocutors was seeringly painful. The mental health worker very much wished to reach out to her, but knew that touch might not be acceptable from a man to an Asian woman – not all the "languages of love" being translatable. Instead he simply held his hand out palm up and the woman gripped it and continued to speak, with intense

eye contact. The woman's eyes filled with tears and the mental health worker's eyes brimmed over also. The woman paused, and with an expression of relief and wonderment on her face, said: "Nobody's ever cried with me before." Those tears of empathy seem to have been the right language at the right time. The faith leader and the mental health worker were able to put the young woman in touch with the right services and community support. She stayed for the rest of the seminar, seeming to find comfort and support from another member of the faith community who shared some of his and his family's struggles with mental illness (see Gilbert, 2010a).

Speaking about the survey undertaken by the former Mental Health Act Commission, its then Chair, Professor Kamlesh Patel stated:

> If you don't know who am I, how are you going to provide a package of care for me to deliver something? When you do not know how important my religion is to me, what language I speak, where I am coming from, how are you going to help me cope with my mental illness? And that is what I'm trying to get over to people; the first step is about *identity*. It is absolutely fundamental to the package of care we offer an individual. (Quoted in Gilbert, 2007a, p. 26, our emphasis)

Increasingly, people in public life are speaking openly about their experience of mental distress, and this seems to be largely helpful. One of the authors (Peter Gilbert) has found that talking publicly about his own experience has almost physically dismantled the walls of stigma. People in the audience can be seen to be breathing a sigh of relief that these matters can be talked about openly; and similarly, with a person's spirituality, the launch of the NIMHE Project in 2001 (see Gilbert, 2007b) meant that many people felt able to speak about their beliefs openly for the first time for many years, as they had otherwise felt that any mention of belief would be seen as a sign of mental illness. As Jean Davison, in her recent autobiography *The Dark Threads* puts it:

> And would the psychiatrist be able to understand my difficulties in coming to terms with the loss of my religious beliefs, about life seeming empty and meaningless, and those hard to explain 'what am I?' feelings? Perhaps he would try to impress upon me all that I ought to be thankful for. (Davison, 2009, p. 10)

For people with a religious faith, there is something more than the empathy of fellow human beings, and even something more than the rituals that pervade organised religion, and provide a framework for moving through life and interacting with other people. It is something which might be described as "divine empathy"; and just to complicate matters for mental health professionals, this feeling of an empathic relationship with a divine being may be strong amongst those who do not affiliate themselves (or perhaps no longer affiliate themselves) to an institutional faith. This empathic relationship may be with a God who is transcendent, rather than immanent, such as in the Islamic faith. Though most Muslims find even the concept of the Christian God becoming incarnate something rather shocking, the concept of *Zikr*, or remembrance of God, is particularly helpful to Muslims. For Christians, especially at a time of suffering, the idea that an all powerful God would have sent his son, Jesus, as fully human as well as fully divine, onto this earth to walk with human beings, and redeem human kind's sins by dying a painful death on a cross, can provide a very powerful symbol of this empathic bond.

> As the first letter of St John put it:
> "Think of the love that the Father has lavished on us,
> by letting us be called God's children
> . . .
> We shall be like him
> because we shall see him as he really is.

...
Whoever keeps his commandments lives in God and God lives in him (sic).
We know that he lives in us
by the Spirit that he has given us.
(The Bible, 1st Letter of St John, 3: 1–2, 21–24)

In partnership work between faith communities and mental health services, stories are a powerful part of the journey. We begin to see people, not as agents as some moral theory or shadows acting out some predetermined script, but real people on a path, who we walk with, at least for a time, and then may diverge and see them, at a distance, on a parallel path. As Neda Soltan, who was killed in the protests in Tehran over the reinstallation of Mahmoud Ahmadinejad, told her fiancé shortly before she was shot: "each person leaves a footprint in this world."

The health benefits of belonging to a religious community

A substantial evidence-base supports the hypothesis that religious belief can sustain well-being and promote recovery, in both physical and mental health. Of particular note Harold Koenig and colleagues, based at Duke University in North Carolina, USA, have reviewed and collated hundreds of studies that examine the relationship between religious belief and mental well-being (Koenig, McCullough, & Larson, 2001). Many studies indicate that active involvement in a religious community makes a person more resilient to mental illness (Koenig et al., 2001, p. 225), which is often attributed to the enhanced social support networks religious communities often provide (Koenig et al., 2001, p. 100). Further, the person's intrinsic religious motivation (the motivation to practise their religion because they feel it is worthy in and of itself, not because of the benefits religion can bring) also has a positive effect on mental health (Koenig et al., 2001, p. 127). The authors also cite studies that disprove the impression that religious content in psychotic delusions results from patient's being more fundamental or religiously active (Koenig et al., 2001, p. 160).

The importance of religious coping for people recovering from mental illness has been well-documented (Koenig, 1998; Loewenthal, MacLeod, Goldblatt, Lubitsh, & Valentine, 2000; Pargament, 1997; Worthington, Kurusu, McCullough, & Sandage, 1996;). Professor Andrew Sims, past president of the Royal College of Psychiatrists Spirituality Special Interest Group summarises the coping abilities that belonging to a religious community can bring as follows:

- *Social benefits*: a sense of belonging
- *Trust in God*: a sense of "rightness" and the security this gives
- *Internal levels of control*: for example, the spirit of the divine and/or moral purpose within me helps me to exert my own will and do better. (Sims, 2009)

It must be acknowledged that there are some risks to health and well-being that come with belonging to certain religious communities, beautifully articulated by Kenneth Pargament in his article: "The Bitter and the Sweet" (Pargament, 2002).

Of course, it is unwise to make general statements that only take into consideration religious affiliation. Islam, for instance, is often seen as a monolithic religion but has a number of diverse strands, heavily influenced by the society and culture in which the strand is found. African Muslims, for example, will often describe themselves as adherents to the Sufi tradition rather than the Sunni or Shia. Muslims from the Indian subcontinent sometimes speak of tensions between them and those from Arab countries, as some

Muslims are of the opinion one can only truly read the Qur'an properly in the original Arabic. Roman Catholics, also widely seen as a monolithic Christian tradition, have some conflictual strands, sometimes highlighted by the immigration from Eastern European countries, bringing a much more traditional interpretation of Catholicism. There are several Sikh Gurdwaras in Birmingham, some communities originating from the Punjab and others from East Africa.

Studies have repeatedly demonstrated that self-harm and suicide rates are higher amongst women who have a South Asian heritage than white women in the United Kingdom (Husain, Waheed, & Husain, 2006). Cultural and ethnic factors are cited as reasons for this disparity, and it should be recognised that these factors have an impact on religious belief, and as a result, the attitudes to mental illness. Studies have indicated that some members of faith communities take longer to seek professional help because of the cultural attitudes to privacy and dignity: "Family problems and emotional problems are kept hidden and not exposed to other people. That is our culture" (Punjabi–Muslim participant in research study conducted by Simich, 2006, p. 33).

Faith and the city

Aristotle noted that "A city consists of differing kinds of humans; similar humans do not bring about a city." Recently, Chief Rabbi, Dr Jonathan Sacks wrote that: "If we were completely different we could not communicate. If we were exactly alike we would have nothing to say" (Sacks, 2007, p. 12). Birmingham is Britain's second city with a diverse ethnic, religious and cultural make up. According to the 2001 Census, 32.8% of Birmingham residents are part of a Black or Minority Ethnic (BME) community, in addition to 5.8% of Birmingham residents classifying themselves as belonging to one of the White ethnic groups but being born outside the United Kingdom. With regard to the religious profile of Birmingham, 59.1% of respondents are Christian, with large minorities of Muslims (14.3%) and "not religious" (12.4%). However, in different areas of the city, like any big city in the world, diverse concentrations of religious and ethnic groups are present. Along one particular main road leading into the city centre, a church attracting a large African-Caribbean denomination sits within walking distance of two prominent Sikh Gurdwaras, catering for the religious needs of minority ethnic groups that make up 76.2% of the population of this area (www.birmingham.gov.uk). Such a mix of ethnicities and religions is mirrored in the Sparkhill area of the city, where one church that serves the local community notes that its parish has the second largest number of Muslim residents of any parish in the United Kingdom (www.stjohnsparkhill.org.uk). Conversely, Kings Heath has a high white, Christian population, whilst neighbouring Selly Oak, with its diverse student population, reports the highest response of "No Religion" in the national census.

The awareness conference with the Sikh community

With particular reference to the Sikh religion, little research into Sikhism and mental health has been carried out. The Mental Health Foundation surveyed charitable projects that address religion and/or spirituality in the delivery of mental health care (Mental Health Foundation, 2007, p. 47). The *Guru Ram Das Project* is mentioned, and is described as an activity based project that delivers yoga, meditation and divine chanting alongside other more secular activities to support those with mental health difficulties.

The only reference to Sikh spirituality states that "the project's primary aim is to draw upon Sikh *dharma* ["righteous path"] to teach a philosophy and way of life that can improve the mental, physical and spiritual health of the individual and their community (Mental Health Foundation, 2007). Sikhs take a holistic approach to illness, and focus on the notion that an internal balance of their spiritual and secular life needs to be maintained in order to be healthy. Links between mind, body and spirit/soul are strong. Within Sikh teaching, there is a strong sense of service and duty to humanity to help those who suffer. It would be part of a Sikh's duty to put the ill person in contact with a doctor or a religious professional. These two routes of care, medical and religious, are generally not seen as in tension, as a Sikh will generally have a respect for medical professionals as this is seen as a profession that serves and helps humanity.

For some Sikhs, superstitious explanations of the causes of mental illness are offered in order to rationalise the "mystery" surrounding it. Concepts such as "the evil-eye," which are not theological ideas found in Sikhism, are offered as cultural explanations to illness. Additionally, taboos surrounding mental illness have arisen because of the effect they are perceived to have on the family and society. A mother with post-natal depression, for example, can be seen as a risk to the family unit. This example arose from the awareness day held at the Guru Nanak Nishkam Sevak Jatha Gurdwara in Birmingham, and has been echoed in previous studies that suggest delay in seeking mental health services relate to negative attitudes surrounding mental illness, arising from the notion that whatever impacts the individual will have a larger bearing on the family network, and thus future generations (Lindridge, Hogg, & Shah, 2004).

It is a mark of courage in an individual or group to recognise that there is an issue which needs to be addressed. The Sikh Gurdwara at Soho Road, Birmingham which has invested heavily in local educational, health and employment provision (see Singh/Gilbert, 2009) were concerned at the issue of mental ill-health still being an issue of stigma for the community. In the discussions around setting up a special awareness conference on the subject, community leaders spoke of the difficulty people had in speaking about the problems openly, and also told a fascinating story of a man, clearly suffering from some form of psychosis, who had been sheltered in the Gurdwara for a number of years, in accordance with the compassionate ethic of the faith, but without any positive links with services. Although earlier access to professional advice and treatment is of course the desired result of an encounter such as this, the compassionate motivation of the members of the community cannot be faulted. After experiences such as this one, the Gurdwara worked with BSMHFT to promote awareness of mental illness, and in doing so began to address a difficult but pervading issue: stigma. The Gurdwara openly advertised the awareness event through posters and radio advertisements, and in holding the open-invitation event on site, gave "strategic permission" to discuss mental illness. This was vital for members of the community to accept the invitation and attend the event, as the stigma surrounding an event such as this was reduced. To aid this further, a moving presentation was given by a member of the community whose sister had recently committed suicide.

As he recounted the series of events and difficult emotions surrounding them, he pleaded with his community to take mental illness seriously and insisted that it could be treated and prevented. This was a powerful message for attendees, as indicated by feedback collected, as the realities of mental illness were personalised. The importance of promoting mental well-being was recognised, and the consolations of faith and being a member of a faith community were remembered. A Sikh psychiatrist from the Trust was invited to present information on the causes of mental illness, and, focusing on depression

and schizophrenia, was able to outline the multiple causes and treatment options that were available, as well as detailing typical symptoms that relatives and friends could be aware of. Members of the complimentary therapies team within the Trust presented on alternative therapies, both talking therapies and holistic therapies, as well as being present throughout the day to give attendees "taster" sessions. The information about alternatives to medication was well received by the community, who re-emphasised throughout the day their need for holistic approaches to this topic. On this note, the Spiritual Care/Chaplaincy Department discussed the importance and practicalities of addressing the spiritual dimension in mental health, and reassured the community that this element of well-being was being increasingly recognised as important in promoting recovery from mental illness.

As a result of the impact this event had on the community, and the effect stigma surrounding mental illness can have on people pro-actively accessing appropriate services, a drop-in service was suggested as an ongoing presence in the community centre part of the Gurdwara. To soothe fears of the loss of confidentiality, the drop-in is set to run at the same time and in the same location as a physical health drop-in service. It was acknowledged that words such as "stress" or "emotion" would be better terms to use than "mental health/illness" because of the stigma already attached to the term "mental." It was felt by members of the community that talking about mental illness in terms of "stress" or "emotional well-being" would be more accessible.

The survey results with the Black-led Church community

In addition to the awareness conferences held at the Sikh Gurdwara, which was repeated with the Black-Led Churches in the north of the city, a survey was conducted amongst attendees of both events to determine attitudes to mental illness. There have been several studies into how the perceived cause of mental illness can affect attitudes to it. These studies have confirmed that assigning a biological, emotional, social or religious cause to an illness affects the way the person who has the illness is viewed. Gureje, Olley, Olusola, and Kola (2006) in their survey of 1163 people in Nigeria, found that those holding a religious or supernatural view of causation of mental illness held a less tolerant view of people suffering from mental illness, and found increased stigma surrounding them, compared to the sample who subscribed to a bio-psychosocial cause.

Attribution theory attempts to offer explanations for the causes of illness. It is rooted in the assumption that people wish to make sense of their experiences of illness, "in an attempt to control and predict these events" (Gureje et al., 2006, p. 104) thus, making it easier to cope with it. Traditionally religious beliefs have provided a framework of interpretation in people's lives that help them understand and cope with illness and this, coupled with other social influences, contribute to what mental illness is attributed to (Hartog & Gow, 2005, p. 265).

Both of these studies were fundamental for the design and development of a sensitive and useful assessment tool that measured religious attitudes to mental illness in three parts – causes, stigma and treatment. Working in line with attribution theory suggested by Gureje, the survey sought to determine how participants linked the attribution of the cause of mental illness to the treatment pathways they sought. The research team then aimed to determine the theological, cultural and philosophical elements of this attribution, by constructing questions that addressed these elements of attribution.

The survey was designed by the research team and sought to determine beliefs about the causes of mental illness, the stigma that surrounds it and the attitudes to different

treatment option. The questions were inspired by Lowenthal's questionnaire targeting people from a variety of religious and cultural backgrounds about beliefs concerning causes and cures of depression (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Further, the Aap Ki Awazi Project (Rethink, 2007) conducted face to face interviews among the Pakistani community, ran focus groups with service users and carers and distributed a postal survey to mental health service providers locally connected to the project based in Birmingham. The report from this research study provided a good working model of community engagement, in addition to highlighting key issues that surround a minority ethnic group – including religious attitudes. The questions asked to focus groups and individuals during the Aap Ki Awazi project influenced the design of the questionnaire used in this study. The research team had their own experiences of involvement with Black-Led Church communities, and were able to contribute insights into the views of this religious group. Additionally academic knowledge of Black theology and Pentecostal and Charismatic theology was utilised, and a literature review established some resources relating to Christian views of mental illness.

A history of miracle healing, found within the religious text (the Bible) and the historical tradition of Pentecostal and Black Christianity, suggests a belief in the ability of intercessory prayer (prayer on behalf of others) and the "laying on of hands" to cure people afflicted with illness, both mental and physical. There is also a presence of thought that attributes demonic possession to the cause of mental illness. Therefore, mental illness is not always recognised as a treatable medical illness, but as a spiritual problem to be resolved through spiritual interventions. These were all taken into consideration when designing the questionnaire, which consisted of a total of 40 questions, split into three categories: *Beliefs about the Causes of Mental Illness; Feelings about Those with Mental Illness;* and *Beliefs about Treating Mental Illness*. Responses were collected using Likert scales for each question.

There were only nine responses collected at the awareness conference at the Sikh Gurdwara, and six of these responses were complete enough to be included in the analysis. Therefore, the Sikh sample will not be referenced here as insignificant statistics were generated in the analysis of the six responses. The research team agreed that a very mixed response was given by those in the Sikh sample, and although it was clear that religious causes and treatments were cited as likely to help, alternative and complementary therapies also were highly cited, as were more medical interventions. A more successful sample was collected from the awareness conference held with the Black-Led Church community. A total of 36 questionnaires were collected at the event which attracted over 70 members of the community, with further attendees from relevant charities and community partners. Of the sample collected, 31 were complete enough for use.

Results: causes and treatment

Hartog and Gow's study demonstrated that for Protestant Christians, knowledge about mental illness was directly associated with their attitude to it – the less knowledge about psychology and mental illness participants had, the more likely they were to ascribe religious or superstitious causes to it (Hartog & Gow, 2005).This trend was echoed in the results collected from the Black-Led Church sample.

As might be expected from a faith community, 95.8% cited "Faith in God" as a treatment that was likely to be very helpful, with other religious treatments being agreed as very helpful (Praying for Yourself: 100%; Others Praying for You: 100%, Seeing a

Religious Leader: 75%, Spiritual Healing/Laying on of Hands: 66%). Many comments that were collected as a qualitative dimension to the study endorsed a holistic approach, suggesting a variety of treatment options be considered alongside each other. This is reflected in the trends described in the quantitative analysis. "Evil forces" or "Demonic Possession" were cited are more likely causes (34.6% of the total sample) than other religious causes such as "Part of God's Plan/Will" (13%), "Sin" (11%) and "Lack of Faith in God" (4%). Of those attributing "Evil forces" and/or "Demonic possession" as a likely or very likely cause of mental illness 70% believed "Seeing your GP" was very likely to be a helpful treatment option, and 60% agreed "Medication" treatment would be very likely to help, in addition to religious/spiritual interventions such as Prayer (100%), Faith in God (100%) and spiritual healing/laying on of hands (90%) agreed. The importance of addressing all dimensions of the person throughout treatment was reiterated throughout the event and the surveys, and of the total sample 28% agreed or strongly agreed that a person with mental illness was also spiritually unwell, implying that spiritual illness would also need to be addressed for the person to recover. About 53.8% agreed that it was the duty of the religious community to help those with mental illness.

Results: Stigma

The results of the stigma section of the questionnaire demonstrated an open and tolerant attitude to those with mental illness, with many comments made regarding the need to help those who are ill, regardless of why they were considered ill. Twenty per cent agreed or strongly agreed that they would feel ashamed if a member of their family or someone they know had a mental illness. No respondents agreed or strongly agreed that they would not want their family and friends to find out if they were mentally ill. Nearly all of the participants disagreed that people with mental illness could be dangerous, with only 10% responding with "Don't Know." This perhaps reflects the community's awareness that Black people who have mental illness are more likely to be labelled dangerous and the knowledge that BME persons were more likely to be detained under the Mental Health Act was commented up on several times throughout the awareness conferences. Only one respondent felt that those who are mentally ill could not contribute to society. In all, 67% of the participants who completed the questionnaire wanted to find out more about mental illness, which was echoed in the feedback collected that asked participants about their experiences of the awareness conference.

Conclusion

Faith groups in Birmingham are at different stages of understanding and raising awareness of mental illness amongst members of their community. From the two events carried out with the Sikh Gurdwara and Black-Led Church community, a number of important issues have arisen regarding the partnership between mental health services and the faith group:

- Faith leaders are committed and highly motivated in engaging with services that promote well-being in line with their religious outlook.
- Language barriers and cultural issues need to be addressed as a priority in order to engage the community in a respectful and effective way.
- An educated religious leader who can sensitively bring together religious attitudes to, and medical knowledge of, mental illness in a holistic approach is an effective way to promote awareness in faith communities.

- Negative attitudes to mental illness should not be dismissed as misguided religious ones – they may be heavily influenced by cultural beliefs, superstitions and ideologies.
- Delivery of services might need to be adapted to suit the needs of the religious community by addressing the influence of stigma and shame, thus improving practicalities of seeking help.
- Issues pertinent to the faith community may also be informed by ethnicity and culture. For example, for the Sikh community, an "Eastern" view of the mind, body and soul in health should be understood and incorporated in addressing mental health and illness.

In conclusion, for the individual religious believer their faith will influence beliefs about the causes and treatment of mental illness, and is a considerably important factor in improving resilience from illness as well as promoting recovery. But religious believers are not just independent faith practitioners. They are influenced by the religious community in all aspects of life, and mental health is no exception. This community emphasis can cause a delay in help-seeking behaviour through fear of stigma; however, the faith community can also be a very important source of emotional, social and spiritual support.

Work between faith communities and statutory agencies is essential and can be very productive (see case example in Gilbert, 2010b, chap. 9). For these reasons, the recognition of the individual's spirituality and faith in its community context should be kept as a central focus throughout the engagement, and not seen as simply another diversity "issue" that needs to be addressed as part of a longer list. A person's spirituality is not an added extra but their *raison d'être*, and should be respected as such.

References

Atherton, J., Graham, E., & Steedman, I. (2010, forthcoming). *The practices of happiness: Political economy, religion and wellbeing*. London: Routledge.

Beckford, M., & Pitcher, G. (2009, December 11). Archbishop of Canterbury: "Labour treats us like oddballs". *The Daily Telegraph*, p. 7.

Burleigh, M. (2005). *Earthly powers*. London: Harper Collins.

Burleigh, M. (2006). *Sacred causes: Religion and politics from the European dictators to Al Quaeda*. London: Harper Collins.

Cook, C., Powell, A., & Sims, A. (2009). *Spirituality and psychiatry*. London: RCPsych.

Davie, G. (2002). *Europe: The exceptional case, parameters of faith in the modern world*. London: Darton, Longman and Todd.

Davison, J. (2009). *The dark threads: A psychiatric survivor's story*. Glamorgan, UK: Accent Press.

Dinham, A., & Lowndes, V. (2009). 'Faith and the public realm'. In A. Dinham, R. Furbey, & V. Lowndes (Eds.), *Faith in the public realm: Controversies, policies and practices*. Bristol, UK: Policy Press.

Friedli, L. (2009). *Mental health, resilience and inequalities report for the World Health Organisation, Europe*. London: NIMHE, CPAG, Faculty of Public Health, Mental Health Foundation.

Gilbert, P. (2007a). The spiritual foundation: Awareness and context for people's lives today. In M.E. Coyte, P. Gilbert, & V. Nicholls (Eds.), *Spirituality, values and mental health: Jewels for the journey* (pp. 19–45). London: Jessica Kingsley.

Gilbert, P. (2007b). Spirituality and mental health: Practical proposals for action. In J. Cox, A. Campbell, & K.W.M. Fulford (Eds.), *Medicine of the person: Faith, science and values in health care provision* (pp. 45–58). London: Jessica Kingsley.

Gilbert, P. (2010a). The bridge of sighs and the bridge of love. In T. Basset & T. Stickley (Eds.), *Voices of experience: Narratives of mental health survivors* (pp. 95–113). Oxford: Blackwell/Wiley.

Gilbert, P. (2010b). (2nd ed. forthcoming). *Social work and mental health: The value of everything*. Lyme Regis, UK: Russell House Publishing.

Gledhill, R. (2009, December 26). Children being forced to grow up too fast, Archbishop warns. *The Times*, p. 16.

Greene, G. (1948/2001). *The heart of the matter*. London: Vintage.

Gureje, O., Olley, B., Olusola., E., & Kola., L. (2006). Do beliefs about causation influence attitudes to mental illness?. *World Psychiatry, 5*(2), 104–107.

Hartog, K., & Gow, K. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Journal of Mental Health, Religion & Culture, 8*(4), 263–276.

Hay, D. (2006). *Something there: The biology of the human spirit*. London: Darton Longman and Todd.

Heelas, P., & Woodhead, L. (2005). *The spiritual revolution: Why religion is giving way to spirituality*. Oxford: Blackwell.

Husain, M.I., Waheed, W., & Husain, N. (2006). Self-harm in British South Asian women: Psychosocial correlates and strategies for prevention. *Annals of General Psychiatry, 5*(7), doi:10.1186/1744-859X-5-7.

Jones, D.A. (2009, December 19/26). Those that dwell on high. *The Tablet*, pp. 4–5.

Jones, D.A. (2010). *Angels: A history*. Oxford: Oxford University Press.

Koenig, H.G., McCullough, M.E., & Larson, D.B. (2001). *Handbook of religion and health*. Oxford: Oxford University Press.

Layard, R., & Dunn, J. (2009). *A good childhood: Searching for values in a competitive age*. London: Penguin Books/The Children's Society.

Lindridge, A., Hogg, M., & Shah, M. (2004). Imagined multiple worlds: How South Asian women in Britain use family and friend to navigate the border crossings between household and societal groups. *Consumption, Markets and Culture, 7*(3), 211–238.

Loewenthal, K., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology, 74*(3), 293–303.

Loewenthal, K., Macleod, A.K., Goldblatt, V., Lubitsh, G., & Velnetine, J.D. (2000). Comfort and joy? Religion, cognition and mood in individuals under stress. *Cognition and Emotion, 14*(3), 355–374.

McMahon, D. (2006). *The pursuit of happiness: A history from the Greeks to the present*. London: Allen Lane.

Measure, S. (2009, December 27). We're loving angels instead: Publishing craze goes celestial. *The Independent on Sunday*, 24–25.

Mental Health Foundation. (2007). *Keeping the faith*. London Mental Health Foundation.

Mickelthwait, J., & Wooldridge, A. (2009). *God is back: How the global rise of faith is changing the world*. London: Allen Lane.

Pargament, K.I. (1997). *The psychology of religion and coping: Theory, research and practice*. New York: The Guilford Press.

Pargament, K.I. (2002). 'The bitter and the sweet: An evaluation of the costs and benefits of religiousness'. *Psychological Enquiry, 13*(3), 168–181.

Pope Benedict XVI (2009). *Caritas in Veritate – on integral human development in charity and truth*. London: Catholic Truth Society.

Pratchett, T. (1996). *Hogfather*. London: Victor Gollancz.

Rethink (2007). *Our voice: The Pakistani Community's view of mental health and mental health services-report from the Aap Ki Awazi Project*. London: Rethink.

Sacks, J. (2005). *To heal a fractured world: The ethics of responsibility*. London: Continuum.

Sacks, J. (2007). *The homes we build together: Recreating society*. London: Continuum.

Sen, A. (2006). *Identity and violence: The illusion of destiny*. London: Allen Lane.

Simich, L. (2006). *Punjabi outreach project: Community report meanings of health, illness and help-seeking strategies among Punjabi speaking immigrants in Hamilton*. Toronto: Centre for Addiction and Mental Health.

Sims, A. (2009). *Is faith delusion: Why religion is good for your health*. London: Continuum.

Singh, M. in interview with Gilbert, P. (2009, July). *The International Journal of Leadership in Public Services*, 5(2), 35–39.

Tart, C.T. (2009). *The end of materialism*. Oakland, CA: New Harbinger Publishing.

The Guardian (2009, January 8). 'Beyond retail therapy'. *The Guardian*, p. 30.

Usborne, S. (2009, November 21). '"Depressed and lonely" model is found hanged'. *The Independent,* 14–15.

Weil, S. (1949/2002). *The need for roots*. Abingdon: Routledge Classics.

Worthington, E.L., Kurusu, T.A., McCullough, M.E., & Sandage, S.J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10 year review and research prospectus. *Psychological Bulletin, 119*, 448–487.