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Deposited in *Repositório ISCTE-IUL*:

2019-02-01

Deposited version:

Post-print

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

Freire, J., Moleiro, C., Rosmarin, D. H. & Freire, M. (2019). A call for collaboration: perception of religious and spiritual leaders on mental health (a Portuguese sample). *Journal of Spirituality in Mental Health*. 21 (1), 55-75

Further information on publisher's website:

10.1080/19349637.2017.1423001

Publisher's copyright statement:

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Running head: RELIGION AND MENTAL HEALTH-A CALL FOR COLLABORATION

A call for Collaboration: Perception of Religious and Spiritual Leaders on Mental Health
(A Portuguese sample).

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Abstract

To assess the relationship and collaborations between mental health professionals and religious and spiritual leaders, eleven representatives of ten different religious affiliations in Portugal participated in this qualitative study. Major findings reported show that, religious and spiritual leaders perceive themselves as important agents in promoting and preserving their congregants' mental health, as well as aiding their recovery processes; however this occurs without much referral to or collaboration with mental health professionals. These findings are discussed, as well as why and how a healthy collaboration between mental health professionals and religious and spiritual leaders can positively impact the psychotherapeutic relationship and clinical outcomes with religiously and spiritual clients, as recommended by several professional codes of ethics and reinforced by the existing scientific literature.

Keywords: Religion; Spirituality; Mental Health; Collaboration; Religious and Spiritual Leaders; Mental Health Professionals.

Introduction

Over the past few decades, research on religion, spirituality and health has gone to great lengths to understand the nature of the relationship between these three dimensions. Although caution is advised when reading and interpreting the results (Seeman, Dubin & Seeman, 2003; Sloan, Bagiella, & Powell, 1999), overall the scientific literature consistently indicates positive associations between holding and practicing religious and spiritual beliefs and improved health mental outcomes (Koenig, 2012; Mills, 2002; Powell, Shahabi, & Thoresen, 2003; Rosmarin, Wachholtz, & Ai, 2011). That is, on the whole, religious people tend to present lower rates of psychological distress, and experience and show much more positive emotions and behaviours (Baetz & Toews, 2009; Hackney & Sanders, 2003; Koenig, 2012; Rosmarin, Krumrei, & Pargament, 2010); experience a greater sense of coherence and social support (Baetz & Toews, 2009; Fallot, 1998; Koenig, 2012); show improved and helpful coping strategies when facing physical or psychological suffering (Abu-raiya & Pargament, 2014; Koenig, 2012; Mueller, Plevak & Rummans, 2001; Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013; Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011); and benefit from religious factors which can motivate, sustain, and consolidate the recovery process (Fallot, 1998; Koenig, 2004). Because of these trends, studies have indicated that those regularly attending religious services, praying or meditating, reading religious literature and the like, are less likely to suffer from psychological disorders, such as depression, suicide, and anxiety compared with non-religious individuals (Cummings & Pargament, 2010; Koenig, 2012; Mueller et al., 2001).

These associations have been linked to lifestyle habits recommended and promoted by many faith communities (Anshel & Smith, 2013; Benjamins, Ellison, Krause & Marcum 2011; Campbell, Hudson, Resnicow, Paxton & Baskin, 2007; Nelson, 2009; VandeCreek, Carl & Parker, 1998). To this end, one particularly important agent in the process of

disseminating and promoting healthy lifestyle behaviours is the religious leader¹ (Anshel & Smith, 2013). Religious and spiritual leaders are often the first source of help for those seeking religious/spiritual and social care within faith communities, and thus they are also the first professional called to assist believers during times of psychological-emotional suffering (Abe-Kim, Gong, & Takeuchi, 2004; Chalfant et al., 1990; Fxxxxx, Mxxxxxx & Rxxxxxx, 2016; Leavey, Loewenthal & King, 2007; Mayers, Leavey, Vallianatou & Barker, 2007; Mitchell & Baker, 2000; Neighbors, Musick & Williams, 1998; Nelson, 2009; Pickard, 2012; Wang, Berglund & Kessler, 2003; Weaver, Flannelly, Flannelly & Oppenheimer, 2003). For this reason, in particular, these professional are often referred to as “*frontline*” or “*gatekeepers*” to mental health issues (Neighbors et al., 1998; Nelson, 2009; Weaver, 1998). Given this proximity, religious and spiritual leaders often provide pastoral counselling, involving basic psychotherapeutic strategies, such as *active listening*, general support, and empathy (Young, Griffith & Williams, 2003), as well as more formal interventions such as cognitive restructuring and problem solving (Jorm, 2000; Leavey et al., 2007; Pickard, 2012). Several studies have shown that pastoral counselling represents an important and prominent part of a religious leader’s work, taking 20% or more of their working time (Moran et al., 2005; Nelson, 2009; O’Connor, 2003; Weaver, 1998; Weaver et al., 2003; Young et al., 2003). It is important to note that people often seek help from religious and spiritual leaders for mental health concerns that are accompanied by religious and spiritual struggles (Sørgaard, Sørensen, Sandanger, Ingebrigtsen & Dalgard, 1996). Conversely, mental health professionals are seldom consulted for spiritual/religious problems (Sørgaard et al., 1996).

Consequently, several studies have been conducted and models were proposed to understand and foster an active and effective collaboration between mental health professional and religious and spiritual leaders (e.g. Breuninger, Dolan, Padilla & Stanford, 2014; Janse van Rensburg, Poggenpoel, Szabo & Myburgh, 2014; Moran et al., 2005;

Thomas, 2012; Wang et al., 2003; Weaver et al., 2003). These studies emphasize the importance of a healthy relationship between these professionals, aiming to not only strengthen therapeutic relationships, but also to enhance therapeutic outcomes, with the ultimate goal of achieving what should be a culturally competent and effective work with religious and spiritual clients. And this could be particularly important for the Portuguese context, considering that, as a country, Portugal is highly religious and, as a society, is quite advanced in terms of religious laws.

Portugal is a secular State; however, socially, historically and culturally, it is undeniably tied to religious beliefs and practices, especially when it comes to the relationship with Catholicism. Specifically, more than 90% of the Portuguese population believes in God, 78% of which believe in a “personal God” and 15% in a “spiritual, higher force or life force” (Menéndez, 2007). In a trans-national comparative study between eight European countries², Portugal appeared as: one of the most religious countries in Europe (surpassed only by Poland); the society that most trusts the Church as an institution (Menéndez, 2007; Duque, 2014) and the only country where, between 1990 and 2008, the number of individuals claiming to belong to a religious institution and to Catholic Church in particular increased (Duque, 2014). In the last Portuguese Census, the two later percentages were even higher, stating almost 85% of the population as religious, the majority belonging to the Roman Catholic Church, 81% (INE, 2012, p. 530, Table 1).

Likewise, as a society, Portugal is quite advanced in terms of religious laws, and remarkable legal steps in terms of religious protection and care have been taken over the years. This includes the regulation of the spiritual and religious care in hospitals and other establishments of the National Health Service, which guarantees that any citizen has the right to have their spiritual and religious needs understood and included when seeking health care

(Law nº 253/2009). Following this Law, a brief and practical manual for the spiritual and religious care in hospital settings was developed by the Religions and Health Working Group (GTRS, 2011). This manual -*Manual de Assistência Espiritual e Religiosa Hospitalar*- aimed, not only, to draw attention to the Portuguese chaplaincy and make it more “*multicultural*”, but most importantly to promote collaboration between health professionals and religious advisers. As portrayed in the introduction text of the manual: “*with this tool, health professionals have an advantage to develop a therapeutic accompaniment that is indispensable to care. Besides, everyone is aware about the therapeutic dimension of spirituality. The religious and spiritual support is essential to the healing and caring of a patient.*” (GTRS, 2011, p. 5)

Insert Table 1 about here

However, to the best of our knowledge, there is no empirical data concerning the extent and importance of the relationship between mental health professionals and religious and spiritual leaders in Portugal. Nor there are any studies aiming to specifically understand the role the latter one plays on their congregations’ mental health status. Therefore, the purpose of this study was twofold: first, to examine the perspectives of Portuguese religious and spiritual leaders on mental health and their congregants’ mental health status; and second to understand religious and spiritual leaders’ perceptions on their relationship/collaboration with Portuguese mental health professionals. Specifically, we used a qualitative methodology to understand the perspectives of religious and spiritual leaders concerning: the main religious and spiritual principles, beliefs and practices related to psychological health and well-being; their religious members’ specific characteristics and needs concerning mental health; the role religious and spiritual leaders play in the promotion, maintenance and recovery of their congregants’ mental health; the possible barriers religious members might

encounter when seeking professional help; perceptions of their current relationship with a mental health professional (e.g. referral and consultation practices; facilitators and/or barriers), and perceptions of the mental health professional competencies when working with religiously diverse clients.

Methods

Given the paucity of previous research among Portuguese clergy on mental health, we used an exploratory and qualitative approach to generate interview data and to understand participants' perspectives, as these methods have been recommended for research in areas where little is known (Elliott, Fischer, & Rennie, 1999). Our approach also facilitated close contact with participants, to learn about their social and material circumstances, their experiences, perspectives and histories. This interactive and developmental process allows for emergent issues to be deeply explored (Snape & Spencer, 2003).

Sampling and data collection

Participants of this study were recruited simultaneously with another study (Fxxxxx et. al, 2016), using a purposive sampling. As such, all participants were recruited through formal contact with the corresponding religious institutions. An invitation letter was sent out, via email, to the institution headquarters requesting the participation of a Leader or Representative, followed by phone calls to ensure invitations were received. Later on, the leaders were chosen and introduced to the first author by the religious institution. Face-to-face interviews were conducted in each participant's setting of choice, most of the time in their congregants' place of worship. All participants signed informed consent forms, agreeing for instance to be quoted.

Participants

A total of eleven religious/spiritual leaders from ten religious institutions were interviewed. The affiliations were the following: Portuguese Baha'i Faith Community; Portuguese Buddhist Union; Catholic Church; Lisbon Israelite Community; Portuguese Hindu Community; Jehovah's Witnesses; Latter-day Saints Church; Orthodox Church; Pagan Federation International and Seventh-day Adventist Church. Despite this religious and spiritual diversity, admittedly most of the participants in this study belonged to minority religious communities, not representing the religious profile of Portugal. This topic, though, will be later on addressed in the Discussion section. Furthermore, two of the participants were female and nine were male; their age ranged from 39 to 64 years old. All participants were Portuguese, except the Catholic and Jewish leaders who were born and raised in Cape Verde and Italy, respectively. For further demographic information, see **Table 2**.

Insert Table 2 about here

Measures

Interview protocol: For the purpose of this research, a semi-structured interview protocol was developed, covering themes arising from literature review and according to the proposed goals. Participants were asked a standard set of questions; however, the interviews were susceptible to change according to the participants' responses, without compromising the course of the goals. Interviews were conducted at the religious and spiritual leaders' offices or/and worship places by the first author. Interviews lasted between 18 minutes, and 2 hours and 10 minutes (**Table 3**). All interviews were audio taped and transcribed in their entirety, and are available for external analysis within their corresponding confidentiality restrictions.

Demographic form: After the interview, participants were asked to complete a demographic form providing some basic information on age, gender, marital or relational status, educational qualifications, employment, ethnic background and experience in mental health services.

Insert Table 3 about here

Data analysis

Prior to the thematic analyses performed using the qualitative software MAXQDA 11, all taped interviews were transcribed by a CIS-IUL intern, and afterwards transcriptions were read with their audios by the first author, to check/correct any mistakes and doubts and also to enable immersion in the data. Once transcription was completed, the first stage of thematic analyses was performed by the first author (*reflexivity*), followed by a second stage, where data was analysed by another coder (the forth Co-author), using the “*intercoder agreement*”¹ available on MAXQDA 11. The final agreement result between the two coders was 78%. The findings presently reported also include the reflections, commonalities, variations and new issues that arose from this methodological approach. Similar methodological approach is described in Carey, Morgan & Oxtoby (1996) and in the previously study conducted. Furthermore, this process of data analysis assisted by software was refined with the steps recommended in Lewins & Silver (2007).

All findings were analysed by the authors, totalling eight different core themes, distributed in 32 codes and 78 sub-codes, in a total of 789 analysis units. The results of the qualitative analysis and the code system created are presented below, in **Table 4**. To ensure understanding of the codes created in this study, a codebook with definitions was developed.

¹Further information on this topic is available in the MAXQDA-Online Manual; section “[The Agreement Testing Concept in MAXQDA](#)”.

Finally, for the purpose of results presentation, the core themes were grouped into five categories, namely: a) *the importance of religion (religiosity) and spirituality in mental health*; b) *the experiences of congregants in the Portuguese Mental Health System*; c) *the role of religious and spiritual leaders in mental health (perceived, performed and/or assigned)*; d) *the relationship and referral to mental health professionals*; and e) *perceptions of mental health professionals' competencies when working with religious clients*. All measures, interviews, data analysis and the complete information on the coding process and results are available for external analysis within their corresponding confidentiality restrictions.

Results

The importance of religion (religiosity) and spirituality in mental health

Across the board, religious and spiritual leaders stated that religion, religiosity and spirituality are important dimensions to the mental health of people around the world. Religion was often referred to as a source of meaning, purpose in life and sense of belonging, as well as an opportunity to have a personal relationship with God(s) and community support, which was referred to as a “way of being in life”, a “privilege” or a “gift”. Notably, few negative aspects of religion were mentioned, such as guilt, feelings of oppression and misinterpretations of beliefs, which could cause mental health problems:

“From the Buddhist’ point of view, human existence is marked by an incessant desire for happiness” [PBU]; “But here it is based on something that is fundamental: knowing who God is... because I cannot have faith without knowing God.” [LDS]; “It helps in the same way that friendly relationships do. Profound relationships, from all the celebration and rituals we have together. It creates a very strong bond between the people that participate in them.” [PFI]; “And of course, if someone is in a situation in which they think that depression is just a problem of lack of faith, when they see a healthcare professional, they may help this person, but he/she will always have some sense of guilt. So

he/she will never feel very happy or comfortable to open up in regards to this part of his/her life”
[SDA].

Insert Table 4 about here

The use of religious and spiritual practices, such as prayer; meditation; reading sacred literature and attending religious rituals were also reinforced, as a way to maintain and restore mental and physical health:

“Baha’is members should work daily on their spiritual life and pray every day; they should read the scriptures every day [PBF]; “We advise our church members to be balanced in their diet... The principle is: anything which creates addiction is discouraged” [LDS]; “One of the greatest gifts Hindu religion gave to the world was yoga, meditation, which is now known worldwide. Meditation helps us to be 100% calm and in peace, both mentally and physically [PHC].

The experiences of congregants in the Portuguese Mental Health System

This topic *-religious members’ experiences when accessing mental health services-* was the most coded category and it included sub-topics such as: religious members’ representation in the mental health system; the most recurrent situations and problems leading them to seek for professional help; the perceived barriers and difficulties religious members might encounter, amongst others.

When asked about the frequency of access of religious members in the mental health system, religious and spiritual leaders raised the issue of their underrepresentation and presented some explanations for such phenomenon. Firstly, religious and spiritual leaders stated that this underrepresentation is due to the combination of members' use of religious and spiritual practices and other factors, such as having a more *"positive and hopeful view on life and of difficulties"* [LDS; JW], the creation of health structures and psychological support for their church members [SDA; LDS; CC], resulting in a *"more quality of life"* [JW].

However, the *"lack of knowledge"* about the intervention of mental health professionals [LIC], along with some fears, dilemmas [PBF; OC; PFI] or even preconceived ideas about therapy [LIC; OC; CC] were also viewed as reasons for this underrepresentation.

All religious and spiritual leaders mentioned the importance of religious member seeking religious and spiritual help first, when in psychological suffering. However, none of the participants discarded professional help. Yet again, religious and spiritual leaders reported the use of mental health facilities when problems or symptoms are more severe and pharmacotherapy is needed, or when the problem is long lasting, and the religious support is/was not enough:

"In general, practitioners of the Buddha's life, when facing difficulties, anxieties, psychological and emotional problems, seek help first with their spiritual master, in a mentor in the community" [PBU]; *"Obviously we seek Gods' help and guidance to give us strength to face difficulties; however, we do not despise medicine's progress, so we seek help there as well"* [JW]; *"There's a part that we can play, there is a part that we cannot play, nor should we try to"* [LIC]; *"When someone is sick, he/she should look for a competent doctor and seek healing. I pray and ask God's help to get better, but also seek a competent physician to be treated"* [PBF].

Most situations, problems or causes for seeking professional help reported were: marital or family conflicts; grief and bereavement; depression, anxiety and guilt; suicide; addictions; eating disorders; physical diseases causing mental health problems (e.g. cancer), being most of these problems also frequent among their congregants.

When questioned about the possible barriers and difficulties religious members may encounter when seeking professional help, some religious and spiritual leaders considered that there are no conflicts or barriers preventing religious people from seeking professional help: *"Hinduism has no barriers, it is a completely free religion. A person does what he/she wants, so there are no barriers when seeking the help of a psychologist or psychiatrist, or any*

other type of professional” [PHC], while others pointed some general concerns and barriers, for instance: religious members’ fears, dilemmas and preconceived ideas about mental health diseases and interventions: “I mean, even me as a pagan; I would be very hesitant to say something about magic to a psychologist” [PFI]; “I think the barriers will appear if the psychotherapist is unaware of the patient’ spiritual quest, or is unaware of the worldview and principles of his/her patient. I think it wouldn’t be a relationship of fulsome understanding” [PBU].

Furthermore, some issues concerning the ability of mental health professionals to work with a religiously client were also raised: *“An Adventist patient has some beliefs and values that may cause some problems if they are ignored or unknown to the mental health professional; for instance, he/she can make suggestions that will challenge the way this patient thinks. So it is not productive at all if a mental health professional doesn’t identify or recognize the patient’s religious identity” [SDA]; “I imagine a patient saying - "I felt better, because in my group we made a spell to improve my health and that made me better". The professional would get this look on their face like "you poor thing, do you really believe in that? You need therapy" [PFI].*

The (perceived, performed and/or assigned) role of Religious and Spiritual Leaders

As expected, participants in this study believed that religious and spiritual leaders play an important role in promoting and maintaining their congregants’ physical and mental health, as well as in aiding the recovery process. This role is mostly related to the dissemination of religious and spiritual beliefs and practices that are ultimately linked to physical and mental health:

“My life as a pastor has been a little bit what we call medical-missionary work, trying to help people with their issues. But more recently, we have also been working hard in the healthy eating area... well

of promoting a healthy lifestyle in general” [SDA]; “We want our members to have the best health conduct as possible” [LDS]; “We promote a healthy lifestyle so that we are not only physically, but also mentally, spiritually and socially healthy” [SDA]; “Our commandments are basically guidelines to make a man more of a man, and a woman more of a woman, in their integrity, in their wholeness, in their fullness. Humanly speaking, but also psychologically and spiritually” [CC].

Regarding their religious members’ recovery process from psychological suffering, stress or mental health issues, participants were asked: *“In these cases, what is your role as a religious/spiritual leader?”* the reports show that participants provided essentially three different types of responses: religious support (*pastoral care*); pastoral counselling and referral or recommendations to seek professional help. Other types of non-specific support were also mentioned, but less frequently.

As such, religious and spiritual leaders in this study mentioned offering mainly spiritual and religious support, in the form of pastoral care (e.g. visitations; meditation; prayers and blessings; reading scriptures, and seeking divine guidance), but also reported the use of therapeutic strategies such as *“listening”, “supporting”, “caring”* and *“advising”*, that in a way also represents the role of a pastoral counsellor. However, none of the participants reported having training in this last field specifically, while only a few reported previous contact with psychology/counselling as disciplines during their academic training to become a pastor or minister.

“When someone is sick, his/her family comes to the temple, they talk to the priest and the priest says prayers in their behalf, asking God to help this person and this family overcome difficulties... overcome diseases” [PHC]; “I remind them about the Buddha’s’ teachings” [PBU]; “When you have a friend who is going through a hard time, you help, communicate, listen, and make her/him see things more positively” [JW]; “I mean, as a pastor, sometimes I have to be, in a way, a psychologist, I do not know if it is a psychologist all the way, but I know that I have to use psychology to help them” [SDA].

Furthermore, and regarding their experience identifying and dealing with their congregants' mental health problems, participants also reported some concerns and difficulties:

"And I also have come across people with serious mental issues, which I don't even know the name of... but we can tell that it is serious stuff, and that I wouldn't be able to do anything. I couldn't even get this person to go to a doctor". [SDA]; "There are cases that we see where this person needs help and sometimes we don't even have the courage to talk about it" [CC]; "About losing someone, for instance... a child died. If they say to me "Father, what can you do for me?", "Nothing, I can cry with you, nothing else." I always say this because it's the only thing that occurs to me, to cry with them... that's so painful. What else can I say?" [OC]

Relationships to mental health professionals

Regarding the current relationship between religious and spiritual leaders and mental health professionals, the few references made to referral and recommendations to seek professional help, often occurred within religious community, as some interviewees of this study reported the creation of health structures and psychological support for church members [\[SDA; LDS; CC\]](#). Those reporting relationships with mental health professionals outside their faith community stated having good-to-very good relationship [LIC; SDA; LDS], while one [OC] reported explicitly having a negative experience: *"A Priest, even a Catholic one has difficulties to work in chaplaincy... sometimes I feel like a stranger. With some exceptions, of course, especially at intensive care service where there is sometimes a good reception of our work"*. The majority, however, reported *no* experience regarding referral to a mental health professional. Furthermore, no references were made by the participants that they were ever invited to collaborate, as an informant or adviser, with a mental health professional working with a religious client.

Concerning the areas of conflicts with mental health professionals, the most concrete examples reported were related to homosexuality, abortion, the use of pornography and masturbation, medication and referral to marriage counselling:

“For instance, we are not concerned with young people [seeking professional help], what concerns us is a psychologist who says he/she does not see any problem with pornography. That's what worries me, because it is the opposite of what we teach” [LDS]; “In that situation, for instance [marital problem, with no domestic violence], imagine that the advice is to split or get a divorce. We make so much effort so that the marriage can be a victory and not a defeat... and this advice could be very practical, saying "look, there are a lot of problems, you should leave for a while", but that might not be the best solution to the problem” [JW].

The perceptions of mental health professionals’ spiritual competence

When asked about mental health professional’ competencies when working with religious and spiritual people, leaders overall perceived professionals to be skilled, open and respectful of religious diversity:

“I believe most professionals are competent; dedicated to their patients. And we do not normally feel much prejudice” [JW]; “Yes, that [openness]. As long as they are open to get to know the person in front of them... I mean in a serious way... at least they will get the necessary information” [PFI]; “A good professional knows or is willing to know the religion behind a patient” [LDS]; “I believe that what is really important for a mental health professional to know is if this person has a spiritual life and how important it is; and also be available to pray with their clients” [PBF]; “I mean we do not like to be discriminated, and usually we aren't. I also see no reason to use discrimination when faced with a mental health professional, a secular or a member of our own religion or of any other religion. We look for competent professionals, who know what they are doing and, of course, to respect our religion” [JW]; “I'm talking about respecting the peculiarities of a culture” [LIC].

However, some concerns were raised regarding mental health professional's religious and cultural knowledge, training and secular values, and the importance of religious matching between professionals and patients, the use of medication, and other issues:

"Hinduism is a religion that is unfamiliar to most people. For instance, people cannot distinguish between Hindu and Muslim or Islamist religion. This is one of the barriers I think psychologists might have" [PHC]; "I think that a psychotherapist who does not know Buddhism, or know at least theoretically what is supposed to happen in a meditative experience, I think will be at a disadvantage for a full understanding of the patient and therefore also for the treatment" [PBU];

"But also it depends on the mental health professionals' training; in case of a mental health professional who is averse to religion, certainly he/she will struggle when dealing with a religious person" [LIC]; "Also if this person has no training in this field. That's another challenge.... But well, that's understandable... you don't have to be trained in everything. It is hard to have the structure I have here" [LDS];

"It would be interesting if this person was an open person, for instance open to the practice of meditation personally. Someone who understands the principles of Buddhism and perhaps has an open view on the nature of mind" [PBU]; "I believe it would probably be easier for a person of a faith, whatever that might be, to work with another person of faith, than an atheist or agnostic to work with a person of faith" [LIC];

"...specifically speaking about psychiatry... they work basically with drugs, and sometimes that's not useful if the rest of the person's life is not working. Well if you need an anti-depressant, take an anti-depressant. But if we can help [with a religious practice] this drug works better and instead of taking it for three years, you may end up taking it only the once" [PFI];

"But sometimes it worries me that the advice might be "leave religion because it makes no sense, it is fanaticism"; so this is what concerns me... that worries us" [LDS]; "I also think that most health professionals are so busy, always running around that, maybe, for them this would be just another thing to add to the pile "wait, now I have to read this regulation ..." [JW]; "There is no control [of the work]. You know, there are crazy people out there... opportunistic people... and professionals should be supervised... even in multidisciplinary teams in hospitals" [OC].

Furthermore, some participants had recommendations for mental health professionals in how to improve their psychological intervention with religiously and spiritual clients:

“Well it doesn’t have to be different with a mental health professional. They should spend more time understanding the religion and spiritual connection of this patient, because that is very important to us” [LDS];

“A professional should know how a Jehovah's Witness, for example, thinks, see things, what is important to her/him or what is less important. This should be part of the information that helps establish the diagnosis and therapy” [JW];

“Health professionals should have an understanding of the patient’s cultural and spiritual context. That way, they will definitely be in a better position to respect this patient's aspirations; and fully understand and correspond to this patient's expectations. That's all it takes: accept and respect their entire being, which also means their spiritual dimension, their beliefs, their deep convictions, and the practices they may enjoy having when they are, for example, hospitalized [PBU];

“Yes, I think that a psychologist or a psychiatrist with this dimension [training]... of course, I know it is not mandatory in your profession, but it would be an advantage for him/her and for patients too, of course. It would be an exceptional job... and sometimes we need support but it is so rare to find psychologists or psychiatrists who also take into account the religious part of the person” [CC];

“I think if they talk to Hindus, they could get to know our traditions... The most important thing is to know that patient, because we are talking about culture... religion and also know a little bit more about the patient’s family [PHC];

“The mental health professional should be able to say “can I pray with you?” Because, somehow, a physician cures, a psychologist heals, but the best healing attracts Gods’ grace... we are channels through which it can move. When we ask for His help, this grace flows better, so it is a tool that is available to any mental health professional [PBF];

“So what we ask out of psychologists is for them to help a Mormon in a way that he/she doesn’t become a drug addict [to medication]; because if that happens, then the problem remains” [LDS].

Discussion

Scientific literature recognizes the role religious and spiritual leaders play in the life of their congregants. In fact, the care they provide has once been called “*the ministry of the cure of souls*”, referring to the acts of help aiming to heal, sustain, guide and reconcile a troubled one within a religious community (Clebsch & Jaekle, 1964, as cited by O'Connor, 2003, p. 5). As aforementioned, religious and spiritual leaders are expected to be, not only the first source of help for those seeking religious/spiritual and social care, but also, in most cases, the first professional called to assist believers in psychological-emotional distress. In fact, in previous studies conducted with Portuguese religious members, results indicated that when (or if) in psychological distress, participants turn first to resources within their religious community, in which religious and spiritual leaders are the first contacted professional, over mental health professionals who were often seen as a possible help, but a last resort (Fxxxxx & Mxxxxxx, 2011; Fxxxxx et al., 2016). However, to the best of our knowledge, there are no empirical studies in Portugal which have attempted to examine the perspectives of religious and spiritual leaders, regarding their engagement with mental health, mental health professionals and mental health illness.

Therefore, the overall goal of the study was to examine the perceptions of Portuguese religious and spiritual leaders on mental health and the current relationship with mental health professionals. We used a qualitative methodology to inquire about: 1) the main religious and spiritual principles, beliefs and practices related to psychological health and well-being; 2) their congregants’ specific characteristics and needs concerning mental health; 3) their (*perceived, performed and/or assigned*) role in the promotion, maintenance and

recovery of their congregants' mental health; 4) the perceptions of their current relationship with the mental health professional and 5) their perceptions of a mental health professional competencies when working with religiously diverse clients.

Religious and spiritual leaders in this study perceived themselves as having an important role in the mental health of their congregants. In fact, this role (and its importance) was reinforced by the participants, who were aware and assumed this role and expectation and reported attending to the members' needs essentially in three different ways: religious support (pastoral care); pastoral counselling and referral or recommendations to seek professional help. Nonetheless, it is important to highlight that the interventions of religious and spiritual leaders in this study was not requested only when members were in distress, but often preventively; meaning they were also responsible for the dissemination and promotion of values and practices related to healthier lifestyle behaviours. Our results were consistent with the perspective that, in fact, religious and spiritual leaders can play an important role in providing and/or endorsing guidelines, initiatives and motivation aiming to increase health in the religious community, but also in assisting and counselling those facing psychological distresses (Anshel & Smith, 2013).

Related to this latter role of *-assistance and counselling-*, it should be highlighted that reports suggest that no participant intended to provide counselling *per se*. However, participants often reported dealing with mental health issues as an important part of their daily work and the use of strategies and techniques associated not only to pastoral counselling, but in some cases with mental health counselling. As such, participants reported assisting and counselling their congregants when dealing with distressing life events, mostly related to depressive symptoms and family problems. Yet, the precise amount of time spent in counselling care was not assessed in this study. These results are consistent with previous

works (Young et al., 2003). Although it was not purposely aimed to assess the level of training and knowledge religious and spiritual leaders have on mental health/illness (i.e. mental health literacy) or yet on pastoral counselling/counseling, this study's participants admitted being untrained not only to accurately assess mental health problems, but also to provide the proper mental health care to the needs of a suffering member. Consequently, participants often reported lacking confidence and skills when dealing with issues related to psychological and mental disorders. Reports of lack of knowledge and training in mental health matters and counselling (as well as the impact thereof) were also discussed in others studies (Leavey et al., 2007; Moran et al., 2005; Pickard, 2012). This issue raises an important question, which for now still remains unclear. If religious and spiritual leaders are in fact the first professionals called to attend to people in distress in their communities, are the reported struggles (caused by the lack of training, knowledge and confidence) delaying the recognizing the need for professional help?

Perhaps these struggles, along with the recognition of professional limitations help explain why the perception, or yet the image, of the mental health professional ability when working with religiously diverse clients was rather positive in this study. In fact, participants included in this study appear to be fully aware of the importance of proper care for mental health problems; often rejected the notions of spiritualization of mental health problems and resolution of these and also considered psychological help as a valid option. Participants were also aware of the principle and need of referral to mental health professionals and considered these crucial to the psychological well-being of their congregants. This awareness among clergy was also reported by Leavey et al. (2007).

It was also noticeable from participants' reports that they were open to dialogue and collaboration with mental health practitioners, as some in fact reported engaging in such

practices in the past. However, evidence suggests that, not only most of the reports of referral occurred within their faith community (as was also reported by Moran et al., 2005), but in some cases participants seemed reluctant to refer congregants for secular psychological services. This occurred particularly in situations related to homosexuality, use of pornography and/or masturbation, abortion or marital problems, and/or when fearing that psychological constructs and interventions would contradict religious beliefs. Divergences and conflicts between religious and spiritual leaders and mental health professionals (as well as the consequences of thereof) were discussed previously by Breuninger et al. (2014), Koenig (2004). On the other hand, no references were made by the participants that they were ever invited to collaborate, as an informant or adviser, with a mental health professional working with a religious client. This was a rather surprising result, considering not only the discourse of participants throughout the interviews, but also the Portuguese cultural and religious context and the multiple legal advances occurred in the past years in Portugal.

The present study is limited to the inherent characteristics of the qualitative methodology used to design, collect, analyse and discuss the data. Firstly, the recruitment process of this study was conducted simultaneously with another study, with religious members (Fxxxxx et. al, 2016); therefore, this sample may be considered small, since participants were limited to the religious institutions that replied and accepted to participate. Furthermore, a purposive recruitment was applied, as most of the participants were nominated by their respective religious offices and/or superiors. Despite not knowing all the criteria used in the identification and selection of these religious and spiritual leaders, perhaps this was based on their knowledge and work experience in health and/or mental health. On the one hand, this could represent an advantage, in the sense that the information collected is in fact privileged, but on the other hand, biased and not representative of all Portuguese religious and spiritual leaders' knowledge and experience, mostly if considering that the

majority of religious leaders in Portugal belong to the Roman Catholic Church (which in this study was represented only by one leader). Therefore, the results cannot be generalized. Nonetheless, these particular limitations *-representativeness and generalisation in qualitative studies-* could be surpassed with the several pertinent points raised throughout the interviews, or even with the religious and spiritual diversity represented in one study. Participants, regardless of their religious and spiritual orientation, were congruent recognising the importance a healthy relationship and collaboration between religious and spiritual leaders and mental health professionals might play in the therapeutic processes of many religious and spiritual clients (Janse van Rensburg et al., 2014).

Conclusions and Implications for Clinical Practice

In an ideal scenario, religious and spiritual issues in the mental health field would “*require more than just passive acceptance*” on the mental health professional’s behalf (Breuninger et al., 2014, p. 151). In fact, the work with culturally and individually diverse people and groups implies the development of specific skills, which ultimately would lead to a proper integration and sensitivity toward a client’s religious and spiritual beliefs (Miller, 1999). In regards to relationships and collaborations with religious and spiritual leaders, mental health professionals would be better equipped to, in a more structured and professional communication, obtain different perspectives of particular faith traditions or belief systems on health and mental health. They would also have the opportunity to clarify or confirm definitions, terminology and scope of belief systems and religious practices, while providing specific information to clients and religious advisers, concerning the risk factors, symptoms, diagnoses and treatment plans (Janse van Rensburg et al., 2014). And this could also represent an opportunity to collaborate with religious advisers that are at a unique position to spot people in distress, suffering and dealing with emotional and psychological issues (Moran et al., 2005). However, it becomes clear from the results that much more

research is needed on religious and spiritual issues to better understand how mental health professionals and religious and spiritual leaders can engage in a more healthy and effective collaboration and therefore accommodate spiritual matters in psychotherapy (Leavey et al., 2007).

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Acknowledgment: Our special appreciation to the leaders who, actively engaged in the interviews and were willing to share their experiences with us.

Conflict of interest: None to disclose

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