9.1 Overview of chapter

I begin this chapter by providing a brief summary of the thesis and then highlighting the main contributions of this study to the literature. I then use the key concepts discussed in my dissertation to briefly examine the relationship between allopathic and complementary medicine in Singapore. By doing this I show that the frameworks and concepts that I have used to study clergymen and mental health professionals can be used to examine other relationships within the health sector. I then offer suggestions as to possible future developments within the traditional and professional mental health sector, especially with regards to the relationship between the two sectors in Singapore and point to the policy implications arising from this study. Finally I present prospects for further study.

9.2 Key findings

In this dissertation, by examining the case of Christian clergy and mental health professionals, I found that the traditional and professional sectors were related to each other in several ways. While much of this relationship, at least on the part of a section of clergymen, was competitive, there were signs of collaboration. The competitive aspect of this relationship could be seen as follows:

1) referral intentions where a significant proportion of clergy were unwilling to make referrals to mental health professionals for presenting problems even when the presenting cases revealed aspects of mental disorder commonly handled by mental health professionals. Clergymen who held constructions of mental and
emotional problems as being spiritually caused, embraced professional ideologies which undermined psychological help, had less network with mental health professionals and who appraised themselves as a profession to be competent in dealing with more complicated presenting problems were less likely to make referrals to mental health professionals for a variety of conditions. Evidently this group of clergymen viewed mental health professionals as a threat to their continued dominance over the emotional and mental concerns of their parishioners.

2) the endorsement of etiological models of mental and emotional disorder which emphasized a spiritual basis. These models were notably the most important predictor of referral intentions and were themselves embedded in the social structure. I showed that clergymen who held on strongly to religiously based causation models for mental and emotional disorder were not as embedded in professional networks with mental health professionals where social influence forces could shape their conceptualization of disorder into those found more frequently in the professional sector. They also had less theological education and thus were more likely to adopt literalist readings of biblical texts unlike their more theologically astute counterparts who could entertain multiple interpretations of biblical passages. Finally those who held more religious models were more religiously conservative and thus less welcoming of non-biblically based interpretations of phenomenon. I argued that despite the availability and training of clergymen in psychology, a broad section of clergymen insisted on the importance of using religiously based models in addition to what was available through psychology. This assertion of the importance of religious models in understanding the cause of mental disorder was arguably important if
clergy were to maintain a competitive edge in their struggle with the mental health profession.

3) the adoption of stringent criteria for selecting referral partners. When clergymen recognized that the presenting problem was undoubtedly beyond their level of expertise or when they assessed that there were legal implications involved in managing a person they were willing to engage in referrals. However clergymen insisted on using stringent criteria to select mental health professionals who they evaluated as trustworthy referral partners. Three criterion - homophily, interprofessionality and social linkage - were important in determining the specific professional that clergymen would view as a referral partner. Those who held most stringently to such criteria were more conservative in their theological orientation, had stronger views of their role identity as counselors to their congregation, attributed greater competence to clergymen for a variety of presenting problems, endorsed religiously based etiology models for emotional and mental disorder and were less connected with mental health professionals. This group was most concerned about controlling the process of referrals because of their perception that referrals to mental health professionals were essentially risky especially from the standpoint of their own professional competence.

4) the settlement strategies of mental health professionals who emphasized that clergy counselling either be directed to areas which bordered on the spiritual or be supervised by professionals in the professional mental health sector. This essentially portrayed the dominance of the mental health sector in handling emotional
and mental problems and the need for clergymen to accept tutelage from this “superior” profession.

While competition between clergy and mental health professionals were clearly visible in this dissertation, an important point of collaboration was notable. On examining how the professional sector related to the clergy sector, it became evident that there was minimum effort to curtail the activities of clergymen in their attempts to increase their own professional status. This was rather surprising seeing that in the US case, mental health professionals have often been rather averse to clergymen and decry their counselling role, preferring that they make referrals as soon as they encounter a request for counselling (Larson, 1964; McMinn et al., 2005; Wang, Berglund & Kessler, 2003). The absence of overt conflict between clergymen and the non-psychiatric mental health professionals that I studied in Singapore was possibly due to the high proportion of Christians found among the ranks of these professional groups. Moreover clergymen and committed Christians served on several helping professional organizations, some in various executive positions. In addition to this, professional counselling in Singapore was initiated and supported initially by the Christian church. The close connection between key Christian leaders and the mental health profession thus augured that less competition ensued.

9.3 Main conceptual contribution to the literature

The main contribution of this thesis is to the sociological study of health and its professions. By examining how two sectors, the traditional and the formal sector of mental health care relate to each other, I have embarked on researching an important area which has thus far not received any attention in the literature. In
undertaking such an investigation, I have highlighted the importance of understanding referrals. This concept has received little discussion, apart from the few pieces of research on job referral practices (Granovetter, 1995; Fernandez & Weiberg, 1997; Neckerman & Kirschenman, 1991; Smith, 2003). Referral intention, as I show, is an important analytical tool for the investigation of the relationship between competing sectors in the larger health care scene. In the absence of any other investigative tool to understand such relations, referral intentions provide a good indicator of how one sector evaluates the other, and the conditions that would allow for a referral relationship.

This thesis not only shows the utility of referrals to understanding the relationship between two sectors, but actually provides a conceptual framework to appraise the conditions that lead to referrals between professionals. Such a framework has thus far been absent from the sociological literature and this study in a substantial way fills this gap. The model that has been developed calls for a careful consideration of the construction of mental disorder among professionals in the different sectors, and aspects of professional dynamics including professional competency, professional ideology, professional role identity and professional networks.

By utilizing various concepts from the domains of health and professionals and applying them to a model which examines referrals, I have contributed to the literature broadly by providing new explanatory power to these concepts. The cultural construction of mental and emotional distress, particularly how cultures explain the onset of mental disorder, a now rather popular notion within the social scientific fields of health (Guindon and Sobhany, 2001; Kleinman, 1977; Joel et al. 2003; Bhui
and Bhugra, 2002) has now been applied beyond its normal confines of examining patient preference for healers, to how professionals in two sectors relate to each other. On that matter, I examined how several variables such as clergymen’s professional networks with mental health professionals, their level of religious conservatism and their exposure to higher theological education were related to their endorsement of spiritual explanatory models for mental and emotional disorder or more psychologically oriented ones. In doing this I have shown that a concept which has normally been understood in purely cognitive terms, has actually a sociological dimension with various structural and cultural forces affecting this cognitive attribution.

Four concepts from the literature on professions namely - professional identity, professional ideology, professional competence, and professional networks - were examined in this study as indicators of referral intentions. These concepts have rarely been applied to understand referral behavior (see Grimm & Chumbler, 1995 for an exception in the study of professional networks and referrals among podiatrists) or gate-keeping behavior. As such their use in a study examining gate-keeping practices extends the utility of these concepts beyond their common usage, to better understand relationships between different professional groups. Not only does this thesis relate these concepts from the study of professions to referral practice, it also provides conceptual links between the variables. This can be seen in the example of the relationship between professional role identity and professional ideology where it was shown that professional role identity in itself was not an element that reduced referral
intentions. It had to be coupled with an ideology which undermined the contributions of another professional.

9.4 Other conceptual and methodological contribution to the literature

Although the abovementioned conceptual contributions are the most significant ones made by this thesis, there are several other contributions that this study makes to the social science literature which are worth mentioning. First an examination of the mental health care practices of Christian clergymen, as part of the services of the traditional sector, is notable since it differs from the normal unit of analysis in studies on the traditional sector which entirely focuses on folk healers, shamans and other ritual specialists (see Kiev, 1964). Researching any helper in the traditional sector is warranted seeing the dearth of information on the activities of this sector despite its popular use in Asia for the resolution of a significant proportion of mental and emotional disorder (Ng, 2000; Ng, Fones and Kua, 2003; Ng and Chan, 2004). However examining Christian clergy provides a unique contribution since this group has not only been a provider of emotional and mental health care for centuries, its tradition has been an important component in the development of the professional mental health sector (Oden, 1987).

Another important contribution of this study has been to the growing literature on trust and more specifically the conditions that lead towards interprofessional trust. Although social scientists have been for some decades examining this concept as well as the associated concept of uncertainty (Luhmann, 1979; Proctor, 2006; Sztompka, 1999), its use in understanding issues to do with the relationship between professionals has been exceptionally sparse. In this study I have shown that trust is a
useful concept to understand the relationship between the formal and traditional sector of mental health delivery in Singapore. Essentially applying Barber’s (1983) definition of trust, referral relationships are based on trust, a trust that clergymen place on mental health professionals who they perceive have some standards of competence and who they hope will not do anything to undermine the faith of the parishioner. I have argued that there is a cognitive and behavioural bases for this trust (Lewis & Weiggert, 1985) and operationalized these bases through the criteria of homophily, social linkages and interprofessionality. These I showed were important markers of this trust relationship between professionals. This in itself forms an important contribution to integrating the concept of trust to the understanding of relationships between professionals in the health sector.

This investigation is also significant for the scientific study of religion especially as applied to the fields of health and professions. For one, this study challenges the theoretical notion held by Abbott (1988) who in his theory of professions alludes to the fact that the secularized and systematic knowledge which the mental health profession created allowed it to win the jurisdictional battle against clergy who had merely a body of religious beliefs. Intrinsic in Abbott’s (1988) argument was that paradigms which were scientific had the greater explanatory power. This assertion however is problematic especially with the increasing move to the re-enchantment of society, where supernatural explanations are once again becoming credible (Bremer, 1981; Chan, 2001). Based on my present study, the integrative stance that many clergymen have adopted to explain mental pathology as a combination of both spiritual and psychological phenomenon has growing currency
even among professional helpers. It then seems that jurisdictional rights need not be regained by purely using scientific explanations. Religious explanations may actually have renewed currency in the present era.

A discussion of the contributions made by this dissertation to the broader literature would not be complete without drawing the reader’s attention to the methodological contribution of this study. Several scales have been developed in this dissertation to understand the various concepts which were hypothesized to have some relationship with referral intentions. An important scale which has been developed in the course of this study has been an instrument to examine the explanatory model of Singaporean Christians and clergymen. While several instruments measuring explanatory models for psychological disorders have been developed (Bhui & Bhugra, 2002; Eisenbruch, 1990; Pistrang & Barker, 2002, Whittle, 1996) only one other attempt exists to explain Christian beliefs about the etiology and treatment of mental and emotional disorder (see Hartog & Gow, 2005). In this dissertation I have been able to propose a scale which meets reasonable standards of reliability and validity. Besides developing an instrument to understand explanatory models, this dissertation has contributed to the development of scales measuring professional identity, professional competence and professional ideology. While these scales have been tailored to understand aspects of the professional behavior of clergymen, adaptations of them might prove useful to other studies attempting to understand the relationship between professional groups.
9.5 Implications of study to the relationship between allopathic and complementary medical practitioner

The main aim of this dissertation has been to understand the relationship between the professional and the traditional sector of mental health provision. I used referral intentions as an analytical tool to understand this relationship since referrals are important indicators of the state of the relationship between professional groups. The growth of professional groups augur that more domains are marked out for various specialties and such “specialist training” engenders that no single professional is deemed capable of handling all kinds of issues himself (Koocher, 1979). As such I argue that the socio-psychological model that I have provided to understand referral behavior is an important step in understanding this process, particularly in the health sector, with the growth of several professional groups besides medical practitioners. These include psychologists, optometrists, podiatrists and chiropractors, who are potentially involved in a referral relationship with medical practitioners. Besides this group of allied professionals, who are essentially situated in the professional sector, the growth in the traditional medical industry further reinforces the need to understand referral behavior within and between health sectors.

In the following sections, I illustrate how the framework used in my dissertation has utility to examine one other set of relationships, namely the relationship between complementary and allopathic medicine. This is important since there has been a growth in the acceptance of complementary medical treatment even among allopathic medical researchers who now accept that at least some therapies are potentially beneficial (Linde et al., 1997; Zollman and Vickers, 1999). Moreover
among Asian consumers, even among those with a Western education, there is a belief in the efficacy of such therapies (Eisenberg et al, 1998; Richardson et al. 2000). With the growing recognition that such traditional forms of medicine have within Singaporean society it will be important to know how this form of medicine can relate to the formal sector which has entrenched itself as the main providers of health care (Lim, Sadarangani et al., 2005).

Just as in the case of clergymen and mental health professionals, the tension due to the threat of invading each other’s turf is a real one. As such the relationship between these two sectors can be seen as competitive with both sides establishing strong professional ideologies which undermine the other profession. However from the standpoint of patient care, there does seem to be at least some evidence that the application of allopathic medicine with its rigorous scientific base of empirical testing, and complementary medicine with its emphasis on holism and care, might be of benefit to the patient (Kaptchuk & Eisenberg, 1998).

For such collaborative efforts to happen between the two health care systems, the model that I have proposed in this study is important to examine how they relate together particularly in the area of referrals, an area that this relationships is most prominent. My model explains such referral intentions as a function of the cultural construction of illness, where different groups attribute different etiologies and subsequent intervention to the same malady, professional behavior where factors such as professional role competence, ideology and networks, and various demographic variables. The model also deems that referral intentions may differ depending on the
presenting issue since different professions rate their competence differently across domains of healing.

When this model is applied to the case of the relationship between complementary and allopathic medicine we can readily see the tension points. The etiological models used by each profession radically differ with allopathic medical practitioners arguing for bio-medical origins to disease causation, where bacteria, viruses and deleterious genes infect and disable the human body. Complementary practitioners on the whole locate disease in the lack of harmony various organ systems experience which result from wrong food or other dysfunctional flows of energy (Jonas & Jacobs, 1996). This then leads to a set of treatment plans which differ, the former prescribing medication which is deemed to arrest the spread of pathogens or provide symptomatic relief, while complementary medical treatment attempts to address the needs of the body by strengthening its immunity through the release of the natural healing properties of the body (Chiappel, Prolo & Cajulis, 2005).

Beyond the tension created by different constructions of disease, referral intention is hindered due to aspects of professional behavior. Professional ideologies abound in both disciplines. Allopathic medical practitioners question complementary medical healers for their lack of scientific documentation of the outcomes of their therapy while complementary medicine practitioners accuse medical doctors of merely treating symptoms but not rectifying the essential problems in the human body (Saks, 1995). Professional networks moreover are nearly always absent particularly in Singapore where practitioners of both forms of medicine are located in different
social class backgrounds, use different languages in primary communication and are trained in radically different educational settings (see Committee on Traditional Chinese Medicine, 1995). Thus there seems to be little in common for these two professional groups to build useful professional networks. Moreover both professional groups see their role identity in the proper management of the patient. Since healing is an important part of the role identity of both allopathic and complementary medical practitioners, this augurs that both professions will find referrals to each other difficult. This is since both groups feel that their personal and group identities are intricately linked to their ability to manage their patients within their health systems.

My research findings on the criteria that clergymen use to make referrals to specific mental health professionals are useful when applied to the case of allopathic and complementary medicine practitioners. As I have shown in the former case, the concepts, interprofessionality, homophily and social linkages are very important criteria professionals, especially those who are of lesser status, use when considering the specific practitioner to make a referral to. When applying this to the case of allopathic and complementary practitioners, it is at once apparent that there are more bridges that need to be crossed, compared to the case of clergymen and mental health professionals. To a large part, allopathic and complementary practitioners do not share much in common, either through their education, value system or socio-economic position and potentially do not have sources for social interaction and linkage. This is unlike the case of clergymen and mental health professionals who are connected through church involvement and to some extent are homophilous. There
then seems to be a greater barrier to cooperation between allopathic and complementary medical practitioners.

While the models that I propose show the tension points which hinder referral intentions between the two healthcare systems, it is also possible to examine ways to alleviate such tension and promote referrals through the findings of my research.

First, a proper evaluation of the professional competence of each discipline by its own practitioners might allow researchers in this field to locate the domains where the different healthcare forms deem themselves most competent. As anecdotally shown, orthopedic and nervous disorders seem to be the preoccupation of many traditional Chinese medical practitioners in Singapore who are normally acclaimed for their expertise in bone setting and curing pains and aches which allopathic practitioners seem to be sometimes clueless of handling. On the other hand, the lack of surgical expertise to deal with problems in dysfunctional parts of the anatomy, such as an infected appendix might deem allopathic practitioners more competent in this area. This then augurs that referral behavior may more easily be recommended by both forms of practitioners to one another when the presenting issue is not within their domains of competence.

Second, as shown in my own research on clergymen and the mental health sector, professional networks are vital to allow a cross fertilization of ideas between the two sectors. It is likely that when professional networks become established, both professional groups will at least have an appreciation of the other’s construction of disease and possibly cross fertilize these ideas with their own. This might then lead to the development of hybrid models which might better address the complexity of
disease. Besides this, professional networks may reduce friction between the two sectors by reducing professional ideologies which undermine each other and increase opportunity for both groups to recognize their respective competencies in healing.

Third, professional role identities can be reshaped through the education of ethics to both professions where the well being of the client is reinforced to be of paramount interest. As I have shown in my research on clergymen, such professional role identity can actually aid or hinder referral behavior. Clergymen, I noted, who held strong professional role identities but did not have a strong professional ideology undermining psychological professions, were willing to make more referrals because the healing of their members was of paramount concern. They were eager to make referrals when they knew that they would not be able to help the particular situation as adequately as another professional. In the same way, if a stronger ethic within allopathic and complementary medical practitioners would focus on the overall well being of the client, regardless of the benefit accrued to the professional, there will be greater likelihood that they would refer to the other practitioner once they realize that there is potential for the better care for the patient.

One possible way that professional networks can be forged, professional role identities altered, and the relative professional competencies of both disciplines being known to each other is through the education of initiates to both these professions. As shown in my study on clergymen and mental health, certain courses in psychological counselling which were targeted to both professional groups allowed for some exchange between the professionals and had its concomitant effect in forging the needed bonds between the two sectors. Likewise in the case of allopathic and
complementary medical students, their being encouraged to attend selected introductory courses featured by both healthcare systems might enable the medical students of both forms, not only to have some basic knowledge of the other healthcare system with its unique constructions, but also develop some ties with future practitioners of a different health care system. This then promotes interprofessionality where both groups of professionals deem themselves in collegial terms which ultimately enhances collaboration.

On a macro level, when a small group of both complementary and allopathic practitioners develop competence in the other health care area, they position themselves ideally to reduce the level of tension between the two systems. Clergymen, as I have shown earlier, who received advanced psychological training were able to assert their influence on the counselling profession and subsequently mitigate the tension level between mental health professionals and the clergy. In the same way such cross trained physicians can likewise provide the needed social influence due to their position in the structural holes between the disciplines and promote collaborative efforts.

9.6 Future trends in mental health care provision

I paid special attention to mental health services of the traditional sector since this sector had received little study despite its historical prominence in mental health provision in many societies. The counselling activities of Christian clergymen were most significant in this regard since they not only have played an important historical role, but continue to be the preferred form of help for a Christian population (Mathew, 2006b).
Christian clergy in my study were intent to continue their role in mental and emotional care despite the rise of the counselling profession and the supposedly increased secularization of the world, which seemingly confined clergy to handling religious matters. In order to continue their role in soul care, ministers did not resort to merely using traditional models to handle emotional and mental issues, as could have been expected by the generally conservative population of Christian ministers who held to fairly fundamentalist views. Instead as Tibi (1993) has noted, fundamentalists often resort to modern technologies to accomplish “ancient” goals. In this case, as I have shown, local clergymen were very open to psychology and embraced its usefulness, attempting to obtain as many tools as they could from this discipline. This was done so that they could continue to be effective in soul care.

The driving force behind Singaporean clergymen’s interest in continuing with their traditional role of mental health provision and their jumping onto the bandwagon of psychology can be at least partially explained by Stark and Bainbridge’s (1987) ideas of the religious economy. The stiff competition of this economy in a site where no single religion dominates pushes clergymen to ensure the continued survival of their churches and denominations. Moreover many a clergymen coming from the ranks of managers and other professionals, view success in terms of achieving quantifiable targets, which in this case was church expansion (Mathew, 1999). To do this, they were always mindful of effectively catering to the needs of the Christian and non-Christian population. As many Singaporean clergymen currently perceive, church growth can best be realized in the Singaporean case, not through the presentation of the truth claims of Christianity but rather in the provision of services,
especially those which clergy have always been doing, namely emotional and mental
care (Mathew, 2005).

Besides considerations of expanding their market share in the religious
economy, Christian clergymen recognized the importance of retaining the loyalty of
their membership. If members were to cease viewing the clergy as authorities over the
mental and emotional domains and subsequently not use their services in preference
to the growing mental health profession, they would as clergymen, lose an important
domain of control over their membership. Thus in order to claim such expertise to
maintain control, they had to demonstrate psychological sophistication since this was
an important worldview of a secularized world.

However clergymen also realized that if they ventured into emotional and
mental care with the tools that the helping professionals use, they would only at best
be considered second class counselors, since they did not dedicate their entire role to
such care. Rather as Abbott (1988) notes, professional groups attempting to make a
case for their role among competing professions had to offer new knowledge. This, in
the local case of clergymen had been in its use of religious techniques in the form of
deliverance, inner healing, prayer or meditation to handle a variety of psychological
and emotional concerns. As I have observed in my fieldwork, clergymen across
denominational lines pursue this new body of knowledge. This is strange since at
least some of these tools were first derived from the more Charismatic branch of
Christianity. The tension between Charismatics and non-Charismatics, so observable
in the Singaporean church scene⁴ would certainly have hindered the use of these
techniques, except for the presence of some strong justifying agenda. In this case it
has been the need of clergymen in general to reclaim jurisdictional boundaries over emotional and mental health care.

While it is clear that clergymen are likely to continue to advance their interests in counselling, I also speculate that with the rising specialization that is occurring within organization and clerical ranks, some clergymen will begin to undertake advanced training in the helping fields and function within their church organizations as clergy counsellors. This is more so likely among those who identify strongly with their professional identity as carers of the soul and mind.

This trend of clergymen embarking on additional training in the helping field and possibly devoting their entire work to minister to those in mental and emotional distress, might then form a unique profession, which I refer to from now on as clergy counsellors. This professional would then be the most likely referral choice for conservative clergymen who place substantial emphasis on the criteria of social linkage, homophily and interprofessionality. Their clergy background which provides them with the needed linkages with the traditional sector, similar values and a commitment to collaborate with clergymen, will allow this professional group of clergy counsellors to thrive within the religious community. Besides his privileged role among clergymen, this professional with his unique training and practice in both fields of religion and psychotherapy might then act as an important bridge between the two professional groups. In the language of social networks, these individuals become structural holes (Burt, 1992) since they are not entirely located in either discipline, and thus have a greater potential to influence both professions.
Arguably the development of a professional group of clergymen skilled in psychotherapy may not remain exclusive to Christianity. Clergymen of other dominant faiths in Singapore may also take up this project to become psychologically sophisticated. This will probably be driven by concerns of the rather competitive religious economy in Singapore. Protestant Christianity has thus far thrived in this market with its ability to quickly adapt to the external environment. The other main faiths have often restructured and rationalized their services based on this Christian model (Tong, 1997). Thus it would not be hard to imagine that these religious groups too, so as to ensure that they do not fall away in their ability to provide for their adherents, will push towards at least a branch of their clergy becoming clergy counsellors.

With the increasing interest of clergymen in psychological counselling and the possible creation of a clergy counselling profession, it will be questionable whether this will become a source of professional competition for the helping professionals. The skilled clergymen undoubtedly will be perceived to be better able to cater to the interest of a religious population and thus will be their primary choice for help. Based on my study of help seeking behavior, it is very much this religiously inclined population to begin with, who are most predisposed to seeking help for their emotional and mental problems (Mathew, 2006b). Thus the loss of this group from the helping professionals’ reach could be substantial. Moreover professional counselling, psychology and social work have all, in recent years embarked on closure to their occupations through licensing attempts. It should thus be seen that
these professions are at least partly concerned about maintaining the boundaries of their expertise.

Despite their concerns, I think it unlikely that the professional sector will actually embark on efforts to strengthen its grip on religious resources as has been the case of the psychological profession in the US (Myers & Williard, 2003; Zinnbauer & Pargament, 2000). As I have shown in the last chapter, the secular context of most counselling services and the strong sensitivity that the state has for the display of religion in secular arenas may prohibit such attempts. Then then further strengthens the possibility of the emergence of a clergy counselling discipline which is uniquely located between both disciplines and thus has legitimacy to explore issues of spirituality in the helping context. There is some theoretical possibility to this considering Abbott’s (1988) framework of the rise of professional groups, where he relates such development of new professional groups to various demands, particularly within the lay population, such as cheaper possibilities to acquire competent help. In this context, I argue that the interest in both religion and spirituality exhibited by a section of the population (Pereira, 2005) together with the respect for credentials (Cheah, 1998) and professionalized services will create a significant niche for clergymen trained in psychological help giving to occupy.

While the rise of psychologically trained clergy counsellor may lead to some tension between the two sectors, I suggest that various forces might actually temper any overt conflict between the pastoral and helping professions. First, as shown in the previous chapter, the relatively large numbers of helping professionals who are religiously affiliated and who display high levels of religiosity might mediate any
overt competition with clergy. Such a group is unlikely to attempt to “hinder God’s work” since they have a high regard for religious authority. Second, various state mechanisms are likely to curb such competition. The Singaporean state’s non-welfarist policies (Lele, 2004) are likely to limit the extent that the helping professionals can gain economically from their services. The growth of the helping profession in the US and parts of Europe have been linked to the state’s high welfare provisions (Lipsky & Smith, 1989), which have fueled insurers to offer high remuneration for mental and emotional health care (Ivey, Scheffler & Zazzali, 1998). This is unlikely in the local scenario where the state has so far resisted high spending in social service provision (Lee, 2001; Ramesh, 1992).

In fact the state might actually welcome the increased involvement of clergymen in mental health provision. Religious institutions are accorded legitimacy by the Singaporean state when they involve themselves in activities conducive for nation building. Thus when clergymen provide professional help for needy individuals, this is viewed as a worthwhile endeavor for religious groups. Moreover these religious professionals are able to mobilize funds for their activities from their adherents which thus provide a source of income which does not burden the state’s coffers. All this then works together with the state’s ideology which asserts that religious and racial communities act as guardians to their respective groups (Chua, 1997).

9.7 Policy implications of study

The findings of this study have several policy implications. First, since collaboration between clergy and mental health professionals is important for
enhanced mental health delivery, particularly in offering timely help to those at risk of developing more severe psychosis, an important role of clergy will be in the detection of possible psychosis among those who seek clergy help. Help seeking from clergy will certainly continue especially among a Christian population who believes in the importance of both psychological and spiritual cures for their mental health needs. Considering the graying population and the fact that end of life issues often include spiritual dimensions, it will not be unrealistic to assume that clergy will be of greater relevance, perhaps even for those who may not be active professors of Christianity but may be concerned about spiritual issues as they contemplate the finality of their lives. As such measures need to be in place to ensure that clergy are better prepared to access mental health risks. Perhaps government initiatives can focus on providing financial support for the training of clergy in identifying psychosis.

Training initiatives however can be complicated since clergy may not necessarily accept the mental health professions’ diagnosis of particular symptoms. As can be seen from the data, clergy were more likely to see psychopathology such as hallucinations or compulsive thoughts which involved Christian content to be spiritual in nature. In reality many of these symptoms may suggest psychopathology which could be treated effectively with medication. Understanding the fears that clergy may have about such medication, more attempts should be made to identify Christian psychiatrists who will be willing to discuss issues of psychopathology without overemphasizing psychiatric intervention. Clergy should also consider dialoguing about the treatment strategies for various counseling scenarios with mental
health professionals who have experience dealing with psychopathology among religious populations. Such dialogue can act as sources of social influence which may steer clergy towards a more positive endorsement of organic treatment models.

In fact it will be imperative if clergy is to be better integrated with the professional sector that mental health professionals recognize the unique roles that clergy play in the care of their parishioners. Collaboration may entail that mental health professionals respect the beliefs that clergy have about the need for possible deliverance or the application of other spiritual techniques for the optimum treatment of patients, while still providing their own set of medical and psychological help.

This study also calls for clergy to carefully consider their view of mental health problems. As has been shown in the etiology models used by clergymen to understand mental disorder, many use models which implicate personal responsibility for the development of such psychopathology. While this belief might make moral sense, it does discount the possibility of organic causes for such disorders. Since at least some forms of psychopathology have been traced to genetic or biochemical maladjustments, the dismissal of such possibilities need to be carefully evaluated. For one, clergy’s understanding of the causation of mental disorder is not private but communicated to members through their encounters and through sermons. These beliefs, especially when they highlight individual responsibility, may have the negative effect of stigmatizing mental health consultations. It is very evident that many, who have mental health issues, do not seek help because of the stigma associated with such consultations. One reason for this stigma is the “loss of face” accorded when one is known to have a mental disorder, possibly since it is believed
that such disorders arise because of the failure of the individual to either live a spiritual life or take proper control over his cognitions and emotions. When clergy continue to reiterate the dimension of personal responsibility in psychopathology they further entrench their members in a belief system which may contribute to unnecessary stigma about these disorders.

Another important consideration that may be appropriate for denominations and theological seminaries pertains to the level of training they provide for clergy in handling mental health issues. Since clergy want to maintain their role in counselling, it will be important to establish whether more training needs to be provided at the seminary level for future pastors to be better equipped for their roles. The realities of modern living and the many complexities and crises that individuals and families encounter raise questions as to whether two courses in counselling may be sufficient especially for those who plan to pursue pastoral ministry. Theological seminaries may want to increase counselling course requirements especially among their students pursuing a pastoral track and perhaps provide the added opportunity for clinical supervision, a crucial learning activity for effective counselling provision. Seminaries should also consider the possibility of a clergy counsellor track which may become the professional who ultimately manages many of the more difficult counselling problems presented to clergy.

9.8 Prospects for future studies

As a result of the empirical and conceptual findings of this thesis I propose several areas for future research. This study has alerted us to the importance of understanding the relationship between health sectors particularly through referral
relationships. One such relationship which is worth exploring is that of allopathic and complementary medicine since the latter system is increasing in prominence globally. A collaborative relationship between these two sectors may augur well for better patient management. Beyond even looking across health sectors to identify sites of tension, the rapid growth in recent years of para-professionals within the health fields means that examining relationships within particular health sectors is equally beneficial.

Also future research projects do well to consider how different practitioners in the health field conceptualize various maladies. In this particular study, explanatory models were of utmost importance to understand how two sectors related to each other. We can similarly expect that understanding explanatory models for various mental, emotional and physical conditions may prove productive in understanding inter-professional relationships.

For a more complete understanding of the total mental health care system, a qualitative study examining the popular sector’s relationship to both the traditional and professional mental sector is needed. The expectations that laypersons, especially religiously inclined individuals have of the ability of their religious leaders to handle their emotional and mental needs provides important insight into whether the traditional sector has successfully maintained its dominance in the care of the mind. An examination of the popular sector will also be insightful in terms of showing whether clergy mediated help is a stage in the whole process of seeking help. Perhaps the initial contact with a clergyman allows the individual with psychological needs to present his problem to someone outside his network of kin. Positive interactions with
clergy then might propel these individuals to seek further help from psychological professionals.

Finally, this study has highlighted a subculture within Singaporean religion, namely conservative Protestantism. As seen through the results of this study, this group at least in the issues surrounding mental health care differed somewhat from other pockets in the population. For instance in my background study on help seeking behavior, Protestant Christian youth highly rated the competence of their clergy in handling mental health issues and showed greater intention to use their services compared to youth from all other religions, even when religiosity was controlled for. This Protestant Christian group was also more likely to cite their concern that secular counselling may be detrimental to their faith (Mathew, 2006b). Similarly Protestant clergymen who were of the more conservative strain continued to have more concerns over “secular” helping professionals, showing concern about their inability to adequately address the problems of individuals. They were also more likely to endorse religiously based etiological models of mental and emotional problems, although embracing psychological worldviews compatible with their beliefs. All this then emphasizes that conservative Protestantism, as in the case of the United States represents a subculture whose difference with the broader population might be substantial (Wilcox, 1998). From norms of raising children and views on a host of moral issues ranging from abortion to sexuality, this group may form a cohesive force championing these causes, possibly against the rising liberalism of a growing proportion of educated secularists (Ellison & Goodson, 1997; Ellison & Sherkat, 1993; Petersen & Donnenwerth, 1998). This then at least in the case of the US, has
come with some societal tension (Woodberry & Smith, 1998). Interestingly however in the case of Singapore, the uniqueness of conservative Protestantism may find resonance with the conservative state, which defends morality as part of a discourse on Asian values (Hill, 2000). All this then makes future studies on conservative Protestantism in Singapore, a worthwhile project.
This recent study in Australia makes use of a small sample to explore possible Christian models to understanding mental problems.

This is evident for instance in the setting up of a double degree programme at the Nanyang Technological University to train Traditional Chinese Medical Practitioners. Further as can be noticed in the media, Channel News Asia the popular local television channel often devotes a segment of their daily health segment to featuring TCM practitioners and their therapies for various ailments.

Religious economy theory utilizes the language of economics to explain the growth and decline of religious institutions. This theory argues that how much market share a religious institution is able to claim within a space is related to how well it competes against other religious institutions. Religious groups and their clergy make rational responses to cope with the opportunities to gain a population of adherents (Stark & Bainbridge, 1987).

This tension is evident from the number of church splits which have occurred over the last 2 decades over issues such as the legitimacy of Charismatic experiences such as speaking with other tongues. In many of my own interviews with clergymen, it seemed that clergymen would inadvertently mention this tension.