

ABUSE OF POWER IN PASTORAL RELATIONSHIPS

Murray Chalmers

Abstract: Pastoral Care, in a mental health setting as elsewhere, ideally offers understanding, comfort and help. But pastors are only human, and can in subtle ways, consciously or unconsciously, fall short of their own standards. This article discusses ways in which power can be abused in the context of pastoral relationships, and gives illustrations and examples from the author's own experience in mental health chaplaincy.

Key words: abuse, pastoral care, relationship of care, revenge

Introduction

It is shocking to consider as a real possibility that we pastors may abuse those in our care. Particularly in a society in which, traditionally, much of the pastoring has been done by Christian ministers or priests, who of all people have before them Christ's command to "love one another as I have loved you." Yet we must face the possibility and, I believe, the actuality, that our practice falls short of our ideals, sometimes woefully so.

Pastors are only human, a condition which guarantees many mistakes. It would be surprising if our work were ring-fenced against any error. Recent years have seen a spate of disclosures and revelations of major abuse done to vulnerable people by religious leaders. If there is so much major abuse, there is likely to be a great deal more of lesser abuse. It is about the lesser abuses that I wish to think in this article.

Power structures and the NHS

In *Pastoral Care and Liberation Theology*, Steven Pattison (1994) argues the case for a Marxist analysis of contemporary British society, the National Health Service, and psychiatric hospitals, as being like Russian dolls one inside the other and each a version of the same pattern. He sees the hospital, for all its splendid ideals – such as the "Patet omnibus" (open to all) carved above the door of the Royal Infirmary of Edinburgh – as a power structure, with doctors at the top and patients at the bottom. He quotes with approval J A Talbot's assertion (*The Death of the Asylum*, 1978, p68) that people

with mental health problems are "one of the most truly powerless constituencies in our society."

Much as I should prefer to dismiss this, it rings too many uncomfortable bells in my experience as a mental health chaplain for me to be able to put it aside so easily. And bad enough as it was that I should recognise aspects of "my" hospital in some of Pattison's strictures, it was even worse to realise that I too am sometimes an oppressor, guilty of abuse of power in pastoral relationships.

A number of years ago, I was in the day room of a ward of learning disability men, all long-term residents. No other staff were present. One of the residents was playing up, being "naughty" in a somewhat 'childish' way. Suddenly an auxiliary nurse burst in and gave him a verbally violent telling off which included much swearing. All of us in the room were very subdued. I was shocked. I reckoned that I had witnessed a piece of abuse by the nurse.

Here is my abuse: I did nothing. This was partly out of shock, partly because I wondered whether this might be standard procedure in the ward, and something to which the residents were so accustomed that they would not take it seriously. (If so, of course, the offence is compounded. If the nurse's behaviour was unacceptable as a once-off event, it is far worse as the latest in a long series.) Partly, whatever other excuses I can manufacture, it was out of cowardice. I failed to do what as chaplain I had the right and duty to do – speak to the auxiliary, or to the charge nurse, to register a protest, or whatever else might have been appropriate. It is a painful memory.

How can I begin to understand what is going on here?

Caring and power

My starting point is the asymmetrical nature of the caring relationship: one person gives, the other person takes; one cares, the other is cared for. That this need not imply any imbalance in status can be seen in marriages and other close relationships where care is given and received without any sense of superiority in the carer or of inferiority in the one cared for. The equality is reinforced by the mutuality of care: today A cares for B; tomorrow B will care for A.

Carers in a number of professions, such as social work, medicine, nursing, ministry, find themselves caring for numbers of people who rarely if ever appear to be able to care for the professionals. If we feel always at the giving end, we may begin to assume that our status is higher than that of those in our care, or we may have that superiority thrust upon us. That perceived difference in status may all too easily be transposed into a potentially damaging imbalance of power.

Power differentials are inevitable particularly in the psychiatric milieu where doctors and nurses can remove freedoms and deny what in other circumstances would be rights. It is sometimes necessary for everyone's good, including that of the mental health service user, that (s)he be confined to a hospital, be kept under constant observation twenty-four hours a day, be medicated against her or his will. Legal safeguards are provided by the Mental Health Act to ensure as far as possible that these powers are not abused. But the result is a big difference in relative power, which can leave the user feeling helpless and at the mercy of the carers. It can also seduce the carers into abusing their power.

This can happen in ways which have less to do with faults in members of staff, than with deficiencies in the way our society looks after people who need care. In acute psychiatric wards, I frequently encounter patients who are waiting for the completion of their discharge procedures. (It is odd that "patients" and "patience" sound so alike: patients certainly require a great deal of patience.) Among a number of possible causes of delay, they may be waiting to see a doctor, or to have their medication

prepared, without which they cannot safely be discharged. This waiting can sometimes last for a whole day. This is unacceptable. The doctor's final permission and the medicine are both necessary. The delay could be avoided.

This accusation is not against doctors or pharmacists, who are often overworked. The fault lies in the distribution of resources, which requires the overwork and causes the delays. In this as in other instances patients are victims of a system of care whose deficiencies include a lack of resources, of which, whatever many and undoubted benefits, can and does abuse patients. This points a finger at all of us who allow defects to continue in our system of care. Within this faulty system, however, there is scope for individuals to exploit and abuse their bits of power, for example by contriving to forget about an unpopular patient who is awaiting discharge.

Nor is the chaplain immune to such more or less subtle exploitations of power. Patients sometimes ask for a chaplain's visit, or for a Bible. If the patient is someone I find hard to like, I may say to myself in effect, "(S)he can wait," and delay the visit or the delivery of the Bible perhaps for an hour or two, perhaps for a day. This is a delay imposed not by press of busyness with other things, but by my decision to procrastinate unnecessarily. I am preventing the patient's getting what (s)he has a right to, and adding to the frustration (s)he feels.

Registers of language, tones of voice, mannerisms, gestures, body language, all come into play. All can betray our perceptions of the relative distribution of power. You may have seen Rikki Fulton's wonderful skit, in which he plays both a Roman Catholic priest stopped for speeding and the traffic cop who stops him. The priest starts by being fawning and placating, the cop by being stern. But gradually the priest (and the audience) start to think that the cop must be Catholic, and the two exchange attitudes until the priest leaves, unbooked, triumphant, waving with a lordly hand a blessing which the cop meekly accepts. (The cop then turns to the audience and says, "And me a protestant!"). The skit demonstrates a step-by-step series of changes in the way the two speak together, which signals the perceived changes in the balance of power.

If I am right in detecting this system of gradations in all our everyday conversation, I think it equally true

that it has its effects. This is particularly so when we speak as though there is a bigger difference between our relative statuses than is perceived by the person to whom we are speaking. I believe further that, although they might not be able to put their finger on it, those treated as inferior feel put down and uncomfortable. People with mental health problems, although they may be out of touch with reality in other ways, can be acutely perceptive of things that concern them, and feel the put-downs keenly. If patients are at the bottom of the hospital heap and mental health patients at the bottom of that layer, they are likely to suffer from all this even more than the rest of us.

Besides their low status, there are other obvious reasons why we may find ourselves treating patients less well than in our better moments we should wish. Patients can be unreasonably demanding. To make a reasonable, caring response that neither puts them down nor makes us their doormats is the correct thing to do, but that can take more energy than we feel we have at the end of a long, difficult day. It is all too easy to take a short cut like a pat answer or a blanket refusal of attention. Some patients are seriously unpleasant people, and "to love the unlovely into loveliness" takes enormous energies. Patients can be frightening. Patients can be seductive, either sexually, or in some other way that manipulates us into giving them more of some thing or other than is good for them or us.

Despite any of these factors or because of them, patients are vulnerable. They may be out of their usual environment, cut off from family and friends, in physical or mental discomfort or pain, afraid of what lies ahead. Those who are most difficult, demanding or threatening may be those who are most insecure. But although I can make allowances in theory, I find it more difficult to make them again and again in everyday interaction.

For any or all of patients' difficult behaviours we may sometimes find in ourselves a desire for revenge of which we may or may not be aware. People with consciences as highly developed as (I would assume) those of ministers and priests know that vengefulness is a "bad thing", and may have strong defences both against allowing it in ourselves and against allowing ourselves to recognise it when it slips past our guard. But I know it happens some-

times, certainly in me. It may, for example, be why I delay giving out the Gideon Bible.

I am not sure that even St Paul escapes suspicion on this issue. I am uneasy about his "heaping coals of fire". Returning good for evil is obviously right and proper, however difficult. But will my motives bear scrutiny? Am I doing it principally so that the doer of the initial evil will feel bad? And is that as bad as I think it is?

If we turn from the motes to the beams, we can find many ways in which we can go wrong without any interference from patients. We may be smarting from some uncomfortable interaction, from the traditional "fight with the wife (or husband)" upwards or downwards on the scale of severity. We may be stressed by overwork or by some health problem of our own. We may feel disempowered in the face of a condition that we can neither cure nor alleviate and, out of our awareness, be angry because of our impotence.

Many years ago I encountered an alcoholic whom I blithely assumed I could cure with a few admonitions. When he failed to get better I did not know what to do, and simply stopped visiting. How he felt about this abandonment, I do not know, but it was patently not a therapeutic or even caring response. The man had ceased to be a person and become simply a failure, from which I wanted to escape.

Impotence may also switch us into fight mode, blaming or even punishing the person whom we cannot cure. Although the association of mental illness with demon possession comes from elsewhere, I suspect that part of its function was to allow those who were frustrated by their inability to cure to take out their frustration on their patients. Some of the frightful treatments that have been in vogue in the past sound more like punishments than anything else. Even today people suffering from depression are frequently subjected to advice which is useless to them (if they could "pull their socks up" they would have done so long ago) but which allows expression to their friends' or families' unaware anger – that they cannot easily be cured, that they continue to be difficult to relate to, etc.

I have already given a few instances of abuses I have spotted in my own practice. Here are a few

more pigeon-holes in each of which I would have to file an incident or two.

- To have favourites among the patients, to whom I give more than their fair share of attention.
- To have “unfavourites” among the patients, to whom I give less than their fair share of attention.
- To give a patient the “brush off” because I want to do something more interesting.
- To give less attention to a patient than to a staff member – especially a senior staff member – who turns up while I am in conversation with the patient.
- To deal with the patient in a way that has less to do with her or his needs and more to do with my need to “do something”, e.g. as a defence against my feelings of powerlessness.
- To tell a patient what I assume (s)he is feeling, saying, thinking or experiencing, rather than listening attentively and allowing her or him to tell me.
- To patronise a patient, especially one with mental health problems or learning disabilities.
- To join with another member of staff in an unkind joke against a patient. (“Unkind” is meant to exclude the kind jokes, which hurt no one. Also excluded are the jokes which help defuse a situation which is hard to bear.)

These are but a few of many ways in which we abuse patients by giving them less than the kind of attention and treatment which we should want were we in their shoes.

Of good practice, I have three examples to offer.

First, on the way to my office one morning, I was accosted in the hospital corridor by a young lady, a long-term patient, who said, “I’m going to hell!” “No, Rose, you certainly are not,” was my reply – which seemed to reassure her. A member of staff who had witnessed the exchange later remarked on the casualness with which I had determined Rose’s eternal destiny. I had certainly been taken unawares by her outburst, and my response was not thought out. On reflection, however, I think it was appropriate. Rose’s distress was the product of her psychotic condition, and I most certainly do not believe that God will damn her for her psychosis. I do however believe that I should exploit any status or authority

which people may give to me as an ordained minister to say as emphatically as I can that God loves them unconditionally. I also believe that such statements, particularly when addressed to people afflicted with the confusions that come with mental illness, need to be simple, clear and unequivocal.

Second, some years ago, I attended an open meeting for the staff and users of a unit in “my” hospital. In the chair was the senior consultant in charge of the unit. Someone came forward with two complaints and proceeded to make one of them, fairly aggressively and at some length. There ensued a discussion in which his points were explored and sympathetically dealt with as far as was possible in the meeting. Then I heard – with disbelief – the consultant say, “Now, Mr....., you had a second point to make.” That was for me an important lesson in how to listen to a person’s frustrations.

Third, in “my” hospital there are from time to time episodes when a very ill, perhaps psychotic, patient erupts into wild behaviour. On such occasions, an emergency summons brings five or six nurses to help control the situation. Sometimes physical intervention is necessary; at some other times the patient assesses the situation and elects to calm down. I once walked into such an episode, and found the nurses standing not far off but a little removed from the patient. With the patient was a senior nurse, who was simply speaking with him. At the end of that conversation, the patient had calmed down so far as to agree to return to his ward, and talk to the staff there about what was bothering him. The senior nurse was able to do this in part because he was well known and respected by both staff and patients. He may (although I cannot be sure of this) have had previous acquaintance with the patient who had run wild. In any case, his calm willingness to listen and speak defused a potentially violent situation.

Conclusion

I am sure that the abuse which is my topic is minor in the scale of such things. I suspect however that it is commoner than we should wish, and that impacts unhelpfully on the patients who are its victims.

As to preventatives, I think that the most important is to be as aware as possible of what is going on in ourselves. If I feel uncomfortable during (or after) an interaction with someone, it is pretty certain that

something has gone wrong, and just as certain that I have contributed to that wrongness. Abuse starts with the moment-by-moment decisions we make to adjust our emotional and psychological equilibrium. If in small matters we can stop ourselves from doing so at others' expense, we may help reduce the likelihood of greater abuses, all the way up perhaps – who knows? – to holocausts and world wars.

References

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Murray Chalmers is chaplain at the Royal Edinburgh hospital, Edinburgh.