

WORLDS APART?

A COMPARISON OF MENTAL HEALTH AND ACUTE HOSPITAL CHAPLAINCY

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ABSTRACT: Starting with a personal account of his own experience as a Hospital Chaplain, working in both the psychiatric and acute sectors of health care, Iain Macritchie makes observations, and draws some comparisons between these two areas of Chaplaincy. Healthcare Chaplaincy, in general, is seen as a dialogue between faith and suffering. The differences between acute and mental health Chaplaincy are highlighted by examining the nature of the theology and of the suffering in either case.

Key words: Chaplaincy, acute, healing, mental health, suffering, theology,

Introduction

My own involvement in Mental Health Chaplaincy came about almost by accident. Rather than lose two sessions of Chaplaincy, I asked for them to be transferred to Mental Health, where I could be of help to the half-time Chaplain already working there. The result is that, at present, I am a whole time chaplain working predominantly in the acute sector, but with two sessions of work each week in mental health.

A sense of difference.

I came to appreciate some of the differences in these two areas of Chaplaincy, as I moved from one setting to another. In the acute sector, there was a real sense of being part of the healthcare team. A large number of referrals came to me from other healthcare workers. I was allowed to ascertain for myself, and from the patients, whether they wanted any involvement of Chaplaincy in their Spiritual Care. On the whole, illnesses were regarded as entirely physical in nature, but that there would be a spiritual element to the care given. There was a fairly clear understanding that I was there as a spiritual caregiver in this context.

However, in the mental health environment there was much less of a sense of being a part of a healthcare team. This was made particularly clear when it came to issues of patient confidentiality. The chaplain would only be told the names of patients who had asked to see the chaplain. There seemed to be the tacit implication that the chaplain, alone among healthcare professionals, was not able to determine for him or herself, the degree to which she or he should be involved with a patient. As well as this, there was the frequent concern expressed that a visit from the chaplain might actually worsen a patient's condition, especially by encouraging religious delusions. In short, religion was often seen as part of the problem.

Another major difference I soon came to appreciate was that the re-admission rate was far greater in the mental health setting, and I would get to know several of the patients well through their frequent visits to the hospital.

What do I think I am doing in an Acute Hospital?

So what am I doing as Chaplain to an acute hospital? I am bringing the acute suffering of human be-

ings into conversation with my understanding of the Christian faith, so that one can inform the other. A number of implications follow from this statement. I need to know as much as I can about my own faith. I need to know something about the conditions of acute illness among which I am working. I need to hold both of these things together, and listen to the unique questions that arise when this happens.

1. I am developing praxis.

It is important for me, in order to do the work of a Chaplain, to be rooted in my own understanding of my own faith tradition, the Christian faith. This is particularly true for me, working where I work because, for many of the people using this service, their own spirituality is rooted in the same faith tradition.

What this rootedness and understanding of my own faith tradition gives me, is a basis, or a foundation on which to construct a theology of suffering. The more understanding I have of my own faith tradition, the more it nourishes me, and enables me to do the work of a Chaplain. It gives me something out of which to care. It also gives me a certain amount (never to be over-estimated!) of shared understanding with those among whom I work.

Christian theology equips me with the spiritual resources I need to go about the work of Chaplaincy in an acute setting. As undergraduates in theology, we were warned that the hospital was no place to go without some kind of theology of suffering – even a basic one. So such texts as Hicks' Evil and the God of Love, or Lewis' The Problem of Pain have been of particular help to me.

Problems arise, however, when theological understanding does not develop or grow, but becomes stuck and entrenched in a kind of 'one size fits all' mentality. In this respect, I would liken Christian theology to a child having access to a whole range of toys in a toy cupboard. The child will want to play with a large variety of toys, will probably have a few favourites, but will learn from playing with them all.

We too need to have a sense, in building our understanding of suffering, and in helping others to find meaning in the midst of their own suffering, of the range of toys available in the cupboard, the different ways in which Christians down through the centu-

ries have wrestled with the problem of pain. There needs to be not just one theological toy that we all have to play with in whatever circumstances we find ourselves. This means that, at best, what we have is work in progress, informed by the efforts of previous workers in this field. But we can construct from that, along with the patients, our own understandings in our own situations.

We need, then, to have a teachable faith that is not afraid to reach out for different understandings of our situation, or even to put all to one side and start again, as a child might well do when playing with toys. We need a sense of creative play in building our own, and others' sense of theological understanding. In a phrase, we need to be consciously developing our own theological praxis in the context of acute suffering.

2. I am developing my knowledge of acute suffering and healing.

While the unique gift that Chaplains bring to Healthcare is undoubtedly their theological and spiritual understanding in the context of suffering, we also have to make sense of the medical terms being used in the hospitals where we work. What does it mean when someone tells us that they have advanced metastatic ovarian cancer? What does it mean when someone tells us that they have had a lumbar puncture, or an MRI scan, or any of the plethora of procedures that occur daily within acute healthcare?

There are those who believe that Chaplains should stay within their own field of spiritual care, and leave all the medical matters to the other healthcare professionals. But if we are moving in the sphere of healthcare, and if we wish to be taken seriously as healthcare professionals ourselves, then we should be prepared to learn the language of the places where we are working, and in so doing, come to a greater understanding of those with whom we work. This will allow us to understand more fully the implications of an acute illness and of its treatment, particularly for the area of spiritual care in which we specialise. This will also allow us to work more cooperatively with other healthcare professionals as part of the care team.

3. 'So that one can inform the other'.

Bringing these two areas together will give rise to a unique set of questions, and Chaplains, as those

trained in articulating spiritual and theological issues and as healthcare professionals, are called upon to explore the possible answers.

Questions regularly arise such as, 'Where is God in my pain?' or 'Is God punishing me?' or 'Is this the devil's work?' Chaplains are regularly asked 'Why me?', 'What have I done to deserve this?' or 'What does this illness mean for me now?' If we cannot begin to help people in exploring the answers to these questions in their own situations, then what are we doing as Chaplains, and why have we gone to the trouble of gaining training and experience in the fields of theology and spiritual care?

However, the process is a two-way one. It is of huge importance that not only do we address pain from the standpoint of faith, but that we also let the pain address our understanding of faith, so that one can inform the other, so that the dialogue might be a genuine one, and so that both patient and Chaplain can grow in understanding of the acute illness and of the spiritual and theological sense that is to be made of that illness.

What do I think I am doing in Mental Health?

So what do I think I am doing as Chaplain in a Mental Health setting? I would give a similar answer to the one previously given regarding acute healthcare, and repeat much of what has been said above, but with an obvious and crucial difference. I am bringing the *mental* suffering of human beings into conversation with my understanding of the Christian faith so that one can inform the other.

When we do this, we find that similar ingredients are present in the work: knowledge of Christian theology, knowledge of mental sufferings and bringing the two together in dialogue. However, the details of the component parts, and the ways in which they come together can help us in understanding the differences between acute and mental health Chaplaincy.

I am developing a praxis of Theology in Mental Health.

As with acute healthcare, the more rooted I am in my understanding of my own faith tradition, then the more I can be nourished in my care of others. But I suggest we use different toys from the theo-

logical toy cupboard, as it were, in the area of mental healthcare.

I find myself drawn more to Vanier and Ulanov. I find myself considering the important spiritual and theological aspects of authors in the field of psychology such as Freud, Jung, Winnicott, Rizutto and Kohut. I find myself, in particular drawn more and more to the ministry of Jesus as recorded in the synoptic gospels. (I also find it interesting to observe in this context that we allow Christ to suffer physically, but are less good at understanding the mental aspects of Christ's suffering, and probably find it impossible to conceive of him being mentally ill.) I also find myself drawn more and more to poetry, which, with its use of metaphor and symbolism, often manages to access and articulate spiritual and psychological issues in a very helpful way. The modern novel can also produce very useful insights into the condition of the human mind.

And, as with acute suffering, the spiritual or theological understanding of mental suffering has to be work in progress, born of a teachable faith. In this process both the Chaplain and the patient can be enriched.

I am developing my knowledge of mental suffering.

As with Chaplaincy in the acute sector, with mental health Chaplaincy some understanding of the conditions being encountered is necessary. What is a psychotic illness? What is clinical depression? What kind of symptoms lead to a diagnosis of schizophrenia? What are the implications of these conditions for the person who is ill, or for those with whom they live? These areas of knowledge are important in mental health Chaplaincy, not so that people can be labelled or pigeon-holed, but so that the chaplain can develop some kind of understanding of the nature of the illness, and of the possible interventions that might be offered. This is particularly true where religious delusion is a significant part of the person's illness, and where the question of feeding these delusions arises.

Also important in mental health is the whole question of aetiology and the prophetic role of the Chaplain. While this is not absent from the acute setting, it does come into sharper focus in mental health. As indicated by Smail, If someone is living in particularly awful circumstances, ill fed, ill housed and

with no outlet for creative energies in terms of work or leisure activity, then it is not particularly surprising that certain mental health issues arise. The Chaplain, as so well indicated by Pattison, has both a pastoral and a prophetic role within the organisation and within wider society, which not only seeks to support those in need, but also calls into question the circumstances that have allowed such needs to arise.

'So that one might inform the other' - A Different Coming Together.

Because the components are different, we can expect the combination of these issues to result in a difference between acute healthcare Chaplaincy and mental healthcare Chaplaincy.

Good pastoral care can offer a critique of mental illness from the standpoint of faith. It can give to the patient, and to the carer, a sense of space to contain what would otherwise be uncontainable, for example, the transcendent, the mystery of suffering, religious experience or even the ultramundane. In this respect, good theology is good psychology and vice-versa. Van Deusen Hunsinger clearly illustrates this point in her excellent book on the meeting of pastoral care and counselling. So our faith should be open to criticism and learning from the pastoral encounter.

Convergences and divergences.

Both models have much in common. They both involve rootedness in one's own faith tradition, but openness to change and to learning. They both involve developing knowledge, understanding and articulation in two fields, the domain of faith, theology and spiritual care on the one hand, and the domain of human suffering on the other.

However, it is noted that, while acute care seems to have been better at involving Chaplaincy and in giving Chaplaincy a place in the total care being offered to patients, mental health care seems more cautious of such interventions. Also, in acute healthcare, Chaplaincy is less directly involved in the healing process, but has a fundamental place in the care of the whole person, and in helping the individual find meaning in the context of acute illness or approaching death, while, in mental health, it seems that good spiritual care is of more direct relevance to the actual condition of the patient. This would suggest

that greater effort should be made to integrate spiritual care into the total care package that is available in mental healthcare, and this for at least two very important reasons.

First of all, in mental healthcare, religious experience has to be taken very seriously. There is a sense in mental healthcare Chaplaincy of hearing the patient's religious experience, not in order to pathologise this, or in order to see it as a feature of mental illness, but to work with this as a potential avenue for healing and wholeness.

We offer to the individual something unique in this aspect of mental health Chaplaincy. We offer something that can house them in the presence of that which threatens to overwhelm them; or house the religious experience itself, so that it can be examined critically. In other words, we offer a sense of inner sanctuary. Religious experience can be overwhelming, and particularly in the context of mental health and mental illness it can be a tremendous source of healing or of damage. By taking religious experience seriously we do not necessarily feed religious delusion, but we can offer the healing function of good theology and a critique of negative religious thinking.

Secondly, in mental health Chaplaincy forgiveness and absolution are high on the agenda. Indeed, one Consultant Psychiatrist in the hospital where I work once stated that he envied me the gift of forgiveness. What he saw was that, like it or not, I could, with the representative authority of my community of faith, declare to people that they were loved, accepted and forgiven by God, and that is a powerful thing in a situation where people so often feel unloved, unacceptable and unforgiven.

Conclusion

The above recognises areas of similarity and difference in the approach to Chaplaincy in two different healthcare settings, and calls to question the caution with which Chaplaincy intervention is often met in mental healthcare.

It is also recognised that, in reality, there will still be areas of overlap between the two kinds of meeting of faith and suffering. Maybe our response to this as chaplains, in a profession which is increasingly moving towards greater specialisation, should be to

ensure a breadth of experience, especially in early years of chaplaincy, and perhaps even to build into our Professional Development Planning and Review (PDP&R) programs, experience of different healthcare Chaplaincy settings, so that acute and mental health chaplains have some experience in each others areas of work, and get to play, every now and again, with toys from a different cupboard.

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References

- BATEMAN M, CRAWFORD R, MCGONIGAL J, 2000 *Scottish Religious Poetry – An Anthology*, Saint Andrew Press, Edinburgh
- FREUD S. 1927 *Future of an Illusion*
- GODWIN G. 1991 *Father Melancholy's Daughter*, Penguin, London
- HICK J. 1968 *Evil and the God of Love* Fontana, London
- HUNSINGER D. V. D. 1995 *Theology and Pastoral Counseling: A New Interdisciplinary Approach* Eerdmans, Grand Rapids
- JUNG C. G. 1968 *Collected Works 20 Vols.* PUP, London
- KOHUT H. 1971 *The Analysis of the Self*, IUP, New York
- LEWIS C. S. 1957 *The Problem of Pain* Fontana, London
- PATTISON S. 1988 *A Critique of Pastoral Care*, SCM, London
- RIZUTTO A. 1979 *The Birth of the Living God*, University of Chicago Press, Chicago
- SMAIL D. 1993 *The Origins of Unhappiness*, Harper Collins, London
- ULANOV A. B. 1986 *Picturing God*, Cowely Publications, New York
- VANIER J. and SHEARER A. 1989 *Community and Growth*, Paulist Press, Toronto
- WINNICOTT D. W. 1971 *Playing and Reality*, Basic Books, New York