Psychiatrists and mental health chaplains: working in partnership

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I write as an ordained minister within the Christian tradition who has spent almost the whole of my ministry employed within the NHS as mental health chaplain. In both of my full-time appointments I worked as community mental health chaplain as well as within the psychiatric hospital and in-patient units. My chaplaincy role was defined as being ‘to meet the pastoral and spiritual needs of patients, service users, their families or carers, and staff, of all faiths and none’.

Alastair Campbell defines pastoral care as care that is ‘concerned with the well-being of individuals and of communities’ (p. 188). As I understand it, pastoral care for mental health that aims to enable well-being must include both pro-active and re-active dimensions. Mental health chaplaincy that is pastoral requires such care to be active in challenging the prejudice experienced by those affected by mental illness as well as in offering the attentive listening and support that is so often required. Chaplaincy that is pastoral and spiritual gives the opportunity for those we care for to be open about their spirituality and to discuss their spiritual needs.

In order to help with the difficulties experienced by people of ‘all faiths and none’, mental health chaplains must be self-aware and able to identify and reflect on our own life and experience. Such self-awareness is important for all mental health professionals: as a ward manager once said to me, ‘you’re no use to anyone else if you’re not okay in yourself – so look after yourself too’. For the chaplain, however, such self-awareness also must include a clear understanding of our own faith or belief tradition: this is essential if we are to help and support those with beliefs very different to our own. Awareness of – and sensitivity to – both the benefits and the potential difficulties created by specific religious beliefs, as well as by individual spiritual experience, is essential if the chaplain is to offer appropriate and sensitive pastoral and spiritual care to people ‘of all faiths and none’.

The Scottish Government’s Guidance on spiritual care and chaplaincy in the NHS in Scotland has this to say about spiritual and religious care:

It is widely recognised that the spiritual is a natural dimension of what it means to be human, which includes the awareness of self, of relationships with others and with creation.
The NHS in Scotland recognises that the health care challenges faced by the people it cares for may raise their need for spiritual or religious care and is committed to addressing these needs.
Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.
Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community (Annex A).
In a footnote to their *Epilogue* in the book *Religion and Psychiatry: Beyond Boundaries* ³, Verhagen and Cook refer to the text of the leaflet produced by the Spirituality Special Interest Group, entitled *Spirituality and Mental Health*:

> The text makes clear that spirituality is indeed seen as the more comprehensive concept, inclusive of, but not confined to, that of religion. Spirituality is described as being universal and at the same time uniquely personal. Religion usually presupposes communal worship along with beliefs and other sacred traditions (p. 622).

Just as the psychiatrist, in enabling patients and service users towards well-being, offers more than medicine, the mental health chaplain offers more than religious care. All mental health professionals are concerned about justice for people affected by mental illness and about supporting people through the difficulties they experience.

What makes the contribution of mental health chaplains unique, however, is that we are appointed and in post because of our faith or belief. That we ourselves have, and believe all people capable of having, awareness of relationship with ‘Spirit’ [the capital ‘S’ here used to indicate Being, or God, however defined by any tradition of faith] is fundamental to our role. Our presence – as people known to believe in ‘Spirit’ - enables people to be open with us about their spiritual needs in ways not possible or appropriate with other members of staff, whose care has for each its own specific emphasis.

Words from the Bible clarify for me my understanding of what my job description means in practice. ‘What the Lord requires of us is this: to do what is just, to show constant love, and to live in humble fellowship with our God’ (Micah 6.8). Doing what is just and showing love is what pro-active and re-active pastoral care demands. Living in relationship with God is what enables the care that I offer to be both pastoral and spiritual.

By working together, in partnership, we can ensure that the holistic care that is essential to well-being is provided. All mental health professionals aim to enable and encourage people to live well, even within any difficulties associated with mental illness. We each have our own unique contribution to make, because of what our particular background, training and skills have to offer. Recognising both where our own particular ‘specialism’ can bring benefit and where the skills and resources of one of our colleagues may be more appropriate is an essential part of care that enables well-being.

Of course, nothing that we offer in mental health care is purely ‘clinical’, whether by that term I mean medical prescription, therapy, counselling or prayer. The relationship we have with those we care for, and care about, is a significant factor in their journey to well-being.

One person, sharing their story in the Scottish Recovery Network’s Narrative Research Project ⁴, summarises the difficulty patients feel when such relationship is lacking.
'You have to fight', this person writes, 'to make people realise that you’re a human being; you’re not just a set of symptoms' (p. 8).

Within some of the other stories published in this research, we hear of the benefits of developing a good relationship:

‘Other people can’t cure you, and you can’t cure yourself, but the two sides working together can help’ (p. 16).

‘She’s [the consultant] prepared to trust me and I’m beginning to trust her, so we have a partnership and that helps to build respect between us’ (p. 20).

‘This social worker recognised a troubled person but also my potential’ (p. 25).

An example from my own experience highlights the importance of the presence of someone who is recognised as being there because they are ‘spiritual’ – the mental health chaplain - as well as the benefit of positive relationship. Visiting regularly on an acute admission ward, I noticed a young woman watching me talk with other patients. One day, she came and laid her head on my shoulder, and whispered quietly ‘you God talk yes?’ This young Bangladeshi Muslim then took me by the hand and led me to her dormitory and we sat down together on her bed. ‘We pray, yes?’ she asked. We sat side by side while I prayed silently for guidance while she prayed out loud in Bengali. After some time she hugged me tight and stated – no longer asking a question – ‘God help me now yes!’ This conversation marked the beginning of her participation in other ward-based activities.

Good relationships with patients and service users can enable and encourage their well-being. Although we recognise that such relationships require boundaries – if we are to be truly helpful to those we care for, we must ensure that relationships remain ‘professional’ and do not become perceived as ‘friendship’ – we also allow a certain ‘fluidity’ and ‘range’ within our relationships according to the need of each individual in our care.

Looking at our role as mental health professionals as being to enable well-being both through expertise and relationship may help to shed a new light on our understanding of partnership, and on our thinking about the boundary between psychiatry and religion.

‘Two sides working together can help’ is how one service user (see quote above) describes the relationship they have with their psychiatrist. Working in partnership with the people we care for helps reduce feelings of dependence and can encourage self-esteem. Feeling more in control, or being given choices, can bring renewed meaning and hope to people whose lives may seem controlled by their illness.

Partnership with colleagues enables us to make best use of one another’s skills and expertise. Discussing each person’s situation within the multi-disciplinary, or care, team encourages everyone to view each as a unique individual with their own unique potential as well as their own unique problems. Sharing the ideas and resources of each professional ‘specialism’, we can better help those we care for towards well-being.
I look now, in particular, at partnership between psychiatrists and mental health chaplains. I began thinking about writing this article after reading correspondence in *The Psychiatrist* about a proposal to set up a working party on psychiatry and religion. John Cox and Alison Gray (p. 118) argue that there is the need to define the boundary between psychiatry and religion. I challenge this view, and suggest that a more helpful approach would be for those on either 'side' of this boundary – psychiatrists and mental health chaplains – to increase the understanding that each has of the role of the other, and to develop better working relationships. Working together in this way, the boundary can be recognised without the need for the strict 'border control' that the search for a clear and fixed boundary might lead to.

Those in our care – those in whom we wish to enable and encourage well-being – do not make clear demarcation between types of need. Enabling a person to discover a sense of hope is an important aspect of spiritual care offered by the chaplain: such hope, however, might be experienced by another individual through the 'light in the darkness' discovered when anti-depressant medication is working well. Not only that, but – as we have seen above – religion is only one aspect of the broader experience of spirituality. The person who begins to feel hopeful through the listening and support of the chaplain may discover such hope through reading together the familiar scriptures of their own religious tradition; but may equally begin to find meaning and hope through contact with Nature, or as he or she is encouraged to renew contact with family or friends.

If we accept that human beings all have the potential to be spiritual and that all people (as stated in the Scottish Government's CEL (2008) 49 quoted above) can have spiritual needs, then it becomes essential that:

- ensuring that spiritual needs are met is seen as the responsibility of all mental health professionals, and
- in order to ensure that spiritual needs are indeed appropriately met, the boundary between 'psychiatric care' and 'spiritual care' remains flexible.

In saying this, I do not, of course, mean that all staff must *offer* spiritual care, but that all staff must ensure that spiritual care is provided. Just as, when working as mental health chaplain, I must refer anyone I meet with who tells me that they are not taking agreed medication to their psychiatrist or nurse, so should other members of the care team refer those with spiritual issues or questions to the chaplain.

Reference to a book about trans-cultural pastoral care may help here. Emmanuel Lartey  says that in order to ensure that care is appropriate to need, we should be aware that '[e]very person is in certain respects: 1) like all others, 2) like some others, 3) like no other' (p. 12). Verhagen and Cook emphasise that spirituality is 'universal and at the same time uniquely personal'. Care that is spiritual, therefore, seen from Lartey's helpful perspective, can be understood as care that recognises that each individual has needs in common with the rest of humanity, as well as needs unique to their particular personality and circumstances.

Religious care, as the Scottish Government's CEL(2008)49 rightly states, is given within the context of shared experience. As Verhagen and Cook say, '[r]eligion
usually presupposes communal worship, along with beliefs and other sacred traditions’. Religious care, we can see then, focuses on those areas of human need that are, in Lartey’s term, ‘like some others’. While such needs do indeed exist, and appropriate religious care can offer necessary help and support, too great a focus on aspects of humanity that are shared with others can lead to unhelpful – and even harmful – assumptions being made about the needs of any individual.

The medical and diagnostic aspects of psychiatry also focus on this ‘like some others’ dimension of human experience. This is clearly essential if appropriate drug treatments are to be identified. Psychiatry, however, is about far more than drugs: appropriate positive relationship with the people who come for help is also an essential element in their journey to well-being. And for relationships to be helpful, Lartey’s other two dimensions are also necessary. People who need help have basic human needs common to all others (including ourselves as carers); acceptance, self-esteem, purpose in life, hope. They also have unique problems and difficulties arising out of their unique, individual response to the particular circumstances in which they find themselves.

Whether psychiatrist or chaplain, it is as we relate to people in these three ways, as human beings like all others, as people with a shared need (medication being appropriate to the illness common to some others; prayer or scripture reading from within their particular community of faith) and as unique individuals facing unique situations. Only then we can enable and encourage them on their journey to well-being.

Defining a clear boundary between psychiatry and religion would require that the focus of care be on those areas of human experience in which people are ‘like some others’. (Asking ‘do they need medication or prayer?’ would be an extreme example of this). The dangers, as stated above, are that people are labelled or categorised rather than being treated as valued human beings with unique individual potential as well as problems, along with the significance of relationship being played down.

Since it is the well-being of those we care for that is the shared aim of all mental health professionals, the question therefore needs to be asked: ‘exactly who would benefit from fixing a clear boundary between psychiatry and religion?’

Instead, by working together in partnership, recognising that spiritual care is an important dimension of the holistic care we seek to offer, psychiatrists and mental health chaplains can learn from one another, share ideas with each other and make appropriate referrals to each other. There is – and should be - a boundary between our roles. Acknowledging it, and then keeping it flexible, however, is the best way of encouraging well-being in all those who require our help.
References


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