

Why do we care for others? – Reflections on a conference about intercultural pastoral care

Rev. Lorna Murray
Mental Health Chaplain Royal Edinburgh Hospital

'If you are meeting with people of different faiths in dialogue, you cannot be evangelising.' This was said to me recently by a Naga friend, with us in Scotland for a few weeks to learn about pastoral care and chaplaincy here. It was said in puzzlement, indeed almost amazement; her negative view of my work as mental health chaplain needs to be understood within the context of her own experience. Nagaland, one of the North East States of India, is a place very different from the predominantly Hindu Indian plains, where almost everyone is Baptist, at least nominally. To her, evangelising means encouraging such people to make a public commitment to Jesus, and to be baptised.

Within the context of mental health chaplaincy in the UK, however, I perceive her comment as a very healthy and positive statement. If I am indeed engaging in genuine dialogue with a person - patient, carer, member of staff - belonging to a faith different from my own, then it is very clear, right and proper that my relationship with that individual has nothing to do with evangelism, with trying to impose *my* understanding of the situation in which the person is, or how he or she might be helped through it.

Sadly, my own experience of mental health chaplaincy makes me aware that many people do indeed assume that evangelising forms part of my job description. From time to time, members of a particular Christian group will approach a chaplain, asking for permission to visit wards, and persuade patients to 'turn to Jesus.' Such groups are usually angry and upset when given a firm 'no' to their request, and there have been occasions when I have been accused of 'not really being a Christian at all' when I explain that my responsibility as chaplain is *not* to impose the way I myself believe in, but to enable the patients I work with to find their *own* solutions to their problems and their *own* strength and support. Occasionally too, my task as chaplain is made more difficult by the attitude of other health care workers who assume that my role is to evangelise, or convert, and who then 'protect' 'their' patients by not making referrals. These staff are, fortunately, few and far between but from time to time, they form a very efficient 'brick wall' between chaplain and patient.

The positive statement that genuine dialogue prohibits evangelising benefits the care of patients in a wider sense also. All mental health care professionals have - rightly so - their own convictions about the benefits of their particular discipline; how medication, recreation, exercise, therapy, prayer, meditation or the learning of new social skills will help an individual towards improved mental health. Coming together as a team and meeting in *genuine dialogue* to identify the needs of the patient is far more beneficial to the patient than the imposition of any particular method or treatment.

What benefits the one being cared for? What is most useful to help a patient along the road to recovery? Which insights will best help develop a patient's self-awareness? How can I help this individual to lead a more fulfilled life? These are the questions that mental health professionals need to ask ourselves.

From September 8th to 13th this year, I was in Basel, Switzerland, attending a conference organised by the Society for Intercultural Pastoral Care and Counselling,

an organisation developed by a group of Protestant churches in Germany. The conference title was 'Why do we serve others? - the ethics of caring: multifaith perspectives', and the purpose was to consider the fundamental reasons *why* people care for others and *how* they do so, by hearing from speakers from a variety of faith groups about the ethics of caring within their particular religious traditions. The intention was not to give us information about their particular faith, but, rather, to focus on 'what is care in our tradition?' and 'why do we care?'

'Does our faith have a system of professional carers?' was a question addressed by most of the speakers. Of interest to mental health workers in general, and to chaplains in particular, as we try to ensure that the spiritual needs of *all* patients are attended to, is that the profession of 'pastoral carer' exists only within the Jewish and the Christian traditions. In practical terms, then, where a chaplaincy service is seeking to appoint a 'chaplain' from another faith group, we can assume that an approach to the local Jewish community, to find someone who will provide pastoral care to Jews in hospital, will result in the appointment of a 'chaplain' who will work in ways with which we are already familiar.

Were a similar approach to be made to a Muslim community, there would, according to the Muslim speaker, be a quite different response. For him, if a patient was to request a visit from a Muslim leader, that patient would be hoping for guidance or information, rather than the supportive listening of pastoral care as it is commonly understood within the traditional context of Christian chaplaincy.

Where a faith community has not developed the role of 'professional pastoral carer', or where the concept of 'pastoral care' either does not exist, or means, when taken out of the Judaeo-Christian context from which it arises, something rather different from what Christian chaplains might assume, then interesting discussion takes place when reflecting on the questions 'what is care?' and 'why care?'

In the West, dominated by the Judaeo-Christian concept of pastoral care, and by hospital-based mental health care, it is important that such discussion does indeed take place. There *are* Muslim 'chaplains' appointed to work in hospitals in the UK; the contribution they make is significant, not just in the work they do with patients of their own faith background, but as they help those of us steeped in the tradition of 'professional pastoral care' to identify what care really is, and why it is that *these particular individuals* are the ones selected to offer such care.

The Christian speaker raised the issue of *professionalisation* of pastoral care as a development that can both be a help and a hindrance to the outcome of care. A positive aspect of having pastoral care as a profession, within the context of mental health care, is that the chaplain can be identified by other care workers as a *colleague*, able to contribute to the whole team approach to caring for the patient. A negative aspect of being paid to care for others is that those of us who earn our living from pastoral care may be reluctant to challenge and change the political, economic and social conditions that may be contributing factors in the poor mental health of the individuals we are trying to help. Being paid to listen, a carer needs people in need in order to keep him or herself in employment; removing the problems that led to the person needing to talk may not be in the carer's own best interests. In this context, too, carers must ask themselves 'what is care?' and 'why am I caring?'

The speaker on Hindu understandings of care spoke of the value of ritual. Several aspects of ritual were seen as beneficial in relation to a person's mental health. Firstly, the act of performing a ritual enables the mind to become focussed, to become steady and calm, as the individual looks outside himself/herself to the help available through the ritual and what it represents. Secondly, a person will go to a Temple in an attitude of expectancy or of hope.

The story-telling aspect of ritual was also emphasised as healing beneficial to mental health. Stories of gods overcoming evil with good, or triumphing over difficult circumstances, are heard at both conscious and unconscious levels, enabling a

person to see both into and beyond their own situation, and to realise that it is not they alone who experience a particular problem or difficulty.

All speakers - Christian, Muslim, Jewish, Hindu and Buddhist - spoke of how 'seeking ideal human behaviour' in relation to 'a being greater than ourselves' is beneficial, both to individuals and to communities. Inner peace, and peace between individuals, communities and racial groups - both significant aspects of good mental health - can be achieved as people seek to live out their faith. All speakers also stressed that the search for relationship with a 'holy other' is not just a personal seeking but a way of acting responsibly towards other people and to care for those in need. As the Buddhist speaker expressed it, the lessons learnt in the silence and the stillness are to be used in 'compassionate activity.'

Is there, then, a *human* desire to care, that transcends all boundaries of faith or culture? Is there an instinct to care? This question was addressed by several of the speakers. Is there something within the experience of being human that means that individuals respond compassionately to the misery of others? Is there a human desire to help, that underpins, or overarches, any culturally or religiously based motivation for caring?

The answer, from the conference, would seem to be 'yes'. It is, however, only through our culture, through our faith - or our lack of faith - that we develop our understandings of care. Caring can only be done within particular circumstances, and by particular individuals or groups, who use the methods particular to their own cultural or faith group.

We can, however, learn from each other and so develop our understandings of what it means to care, so improving our ability to care more sensitively and effectively. This is not just true in relation to learning from other faiths and cultures. As mental health professionals, we learn about caring; we learn from other professionals, from voluntary organisations, and from the families and friends of our patients, who care for them, day and night, with or without our help and support.

'If you are meeting with people of different faiths in dialogue, then you cannot be evangelising.' As carers, we can learn much from those who belong to different cultures and faiths, those for whom caring has its common root in the human desire to help, and yet having outworkings and outcomes which may differ widely from our own.

The Hindu speaker at the conference offered 'authentic engagement' as a Hindu definition of caring. In conclusion, I would like to suggest that such 'authentic engagement' needs to be found in *all* our caring. Authentic engagement enables us to value our own culture, our own teaching, our own professionalism and our own faith, while at the same time truly valuing the culture, the teaching, the understandings and the faith of the other. Authentic engagement will not let us push forward our own views.

Authentic engagement enables us truly to listen, truly to engage with the one in need, and to use all that is in us to realise all that is in the other, so that with our support they are enabled to continue on their journey toward full mental health.

Why else do we care?