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articles

The number of older people is increasing and many of them are fit, rich and have friends and relatives abroad. There seems to be sufficient evidence to suggest that flights with current cabin environments may challenge mental and physical health. It may be that the costs of increasing oxygen concentrations, humidity and leg room are small compared with litigation or losing passengers when they become better informed. Despite the Warsaw Convention (1929) stating that airlines are not responsible for their customer's health (passengers are responsible for their own health), there are sufficient concerns to warrant comprehensive research and monitoring of the welfare of aircraft passengers.

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## Significance of the chaplain within the mental health care team

In psychiatric care, where patients experience a wide range of difficulties – emotional, physical, mental, social and spiritual – care must be given to the patient as a whole person. This article is about the significance of the presence of the chaplain within the mental health care team as it seeks to offer this holistic care.

The relationship of the spiritual to the total well-being of the patient is expressed well by Nelson (1999) in her definition of spiritual needs:

'The search for meaning may find expression in the 'why?' questions which are commonly asked in the context of illness, and which give voice to anxiety, anger, guilt, loneliness and other such difficult emotions. Such questions may express a need for acceptance, hope, forgiveness and love.' (p. 77)

Although not suggesting that the chaplain is the only person concerned for patients' spiritual needs, I do argue here that acceptance of the chaplain within the mental health care team contributes significantly to holistic care. This is, I believe, for two main reasons. First, because the mental health chaplain is involved in the world of spirituality and religious belief as well as in the world of mental health care, he or she is in the unique position both of being employed by the trust as a spiritual expert or advisor and of being seen by patients and staff as a legitimate person with whom to raise issues of a spiritual, or more specifically religious, nature. Second, in a psychiatric hospital or unit where many patients have difficulties in forming healthy relationships, a care team that is seen, by its very make up, to have care of the whole person at its heart and is observed to have discussions, debates and even arguments among its members about matters physical, mental and spiritual can act as a model of a healthy relationship for the patients it seeks to help.

The care offered by the chaplain, reflecting on the example shown by Jesus, is known as 'pastoral care'. The clearest definition of this is given by Lartey (1997):

'Pastoral care consists of helping activities, participated in by people who recognise a transcendent dimension to human life, which by the use of verbal or non-verbal, direct or indirect, literal or symbolic modes of communication, aim at . . . relieving or facilitating persons coping with anxieties. Pastoral care seeks to foster people's growth as full human beings together with the development of ecologically holistic communities in which persons may live humane lives.' (p. 9)

As a mental health chaplain, with pastoral care as my purpose, my work is to help patients to discover meaning in their lives – meaning even within their illness – and to be alongside them as they ask the questions 'why me?' or 'what have I done to deserve this?', vent anger at the God they doubt exists and reflect on their lifestyle or share past hurts.

For those experiencing acute or enduring mental health problems, pastoral care on its own may not be sufficient. The mental health chaplain, however, when accepted as a member of the care team, is able – because of his or her presence in the worlds both of spirituality and pastoral care and of mental health care – not only to contribute the pastoral care dimension to mental health care, but also to take an understanding of mental illness and mental health care into the local churches and other faith groups in which he or she is also accepted. I use the word 'world' deliberately because ideas and beliefs earthed in a real person, who is able to relate across the gulf often found between religious and health care professionals, can, instead of being dismissed as remote or irrelevant, be shared in earthly, practical ways for the benefit of patients in hospital and living in the community.



Two examples are relevant here. The first concerns Catriona (names and details have been changed to maintain confidentiality), a patient attending a day unit. She described herself as evil and asked me if I could arrange for an exorcism to be performed. Her psychiatrist felt that this could do no harm and might ease some of her anxieties. In discussion in the multi-disciplinary team meeting, however, I was able to highlight the potential danger: an exorcism that did not 'make her better' could result in her feeling extreme guilt, believing that she was so evil that even God could not help her. It was decided – with a successful outcome – to continue instead with encouragement to comply with medication.

Andrew is a middle-aged man with a schizophrenic illness who began attending a small parish church. His behaviour was experienced by some elderly people in the congregation as intimidating and the priest contacted me for advice. I was able to talk with the priest about how he might respond to any intimidating behaviour. I also spent time with the patient, both to reassure him of his welcome at that church and to help him to see what aspects of his behaviour could be perceived as frightening. With the priest feeling more confident in what was, for him, a new situation, fear was reduced within the congregation and the man was made welcome at Sunday Mass.

Not only is it important that the mental health chaplain is trained and experienced in both pastoral care and mental health care, but it is necessary also that he or she is self-aware enough to understand his or her motivation – with its personal, emotional and spiritual dimensions – and at ease with his or her own beliefs and theological understanding. The latter is essential if the chaplain is to be able to work constructively with patients of any faith, or of none, and to discuss mental health issues appropriately with members of the whole range of faith communities found in the UK today.

Such self-awareness within the chaplain is necessary to enable a continuing 'inner dialogue', as well as discussion with colleagues, about the relationship between the chaplain's training, experience, theological understanding and spirituality and his or her practical outworking in pastoral care. Theory and practice each influence the other, and the chaplain must be open to the influence that each has upon the other. In particular, it is likely that listening to the experiences of individuals in psychiatric care will challenge not only the theological assumptions of the chaplain but also those of religious traditions. It will be necessary, then, for the chaplain not only to reflect on, and be prepared to modify, his or her own understandings but also to challenge assumptions within faith communities. This requires courage, and the chaplain can benefit from the support and encouragement given by colleagues in the mental health care team.

Historically, chaplains have not been encouraged to seek support; in some church traditions, the acknowledgement of vulnerability within a vicar or priest is still discouraged. Support within the mental health care team, therefore, not only helps the chaplain but also enables him or her to encourage a more sharing approach to pastoral care within faith communities. Sharing and support within the team can be of benefit also to psychiatrists, who are not always encouraged to look inward and reflect on such important issues as motivation or vulnerability.

A group I worked with as chaplain in Sheffield helped me, along with registrars and senior house officers, to develop psychotherapeutic skills with patients through a study of theory and reflection on our own experiences, both professional and personal. Each of us took turns in sharing an account of our relationship with a patient with whom we were finding it difficult to work. These case studies exposed our difficulties as well as our abilities in relating to patients, and also revealed experiences from our own pasts – sometimes painful – that were getting in the way of offering positive help to a particular patient.

Such openness and honesty took courage, but as a group we helped each other to grow together: grow in our trust of each other and in our ability to make use of psychotherapeutic skills in our work with patients. My own understanding of the value of that group, as one chaplain among several psychiatrists, is that we learned also to respect one another's traditions, backgrounds and beliefs. Such respect can only benefit the patients with whom we work. Multi-disciplinary training can provide an excellent opportunity to learn together and to learn how to work together as a team.

Acceptance of the aim of working together to offer holistic care means accepting the skills and insights that each professional brings. Where the chaplain is part of the mental health care team, it becomes possible to discuss the spiritual dimension of caring in a more informed way. With the meeting of spiritual needs recognised as part of the necessarily holistic care offered to patients, such working and sharing together within the multi-disciplinary team should be welcomed and encouraged.

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