Two separate experiences as a psychiatric chaplain are the basis for this retrospective, which stems from a thirty-year career in specialized pastoral care. The first began with a clinical pastoral education (CPE) residency in 1974-1975 at Lutheran General Hospital, Park Ridge, Illinois, followed by a position as psychiatric chaplain at the same institution until 1989, including an assignment at what came to be known as the Parkside Center, Lutheran's chemical dependency treatment facility. Fourteen years later, an opportunity arose to once again serve as a hospital-based psychiatric chaplain this time at Alexian Brothers Behavioral Health Hospital, Hoffman Estates, Illinois.

These two assignments represent two distinct models of psychiatric chaplaincy: the chaplain as primarily a therapist and the chaplain as primarily a spiritual caregiver. Use of the term “psychiatric chaplaincy” throughout this article refers to hospital-based chaplaincy on either psychiatric or substance abuse treatment units and is meant to be synonymous with the phrase “behavioral health chaplaincy” more commonly used today. Further, the assignments occurred in ministry contexts with key differences. While the author acknowledges the risk of looking back nostalgically upon a “golden era of chaplaincy” that is now gone forever, one important question remains: to what degree does ministry setting determine ministry roles?

Chaplain as therapist
Lutheran General Hospital is a large tertiary care general hospital, which in 1974 had multiple inpatient psychiatric units and one partial hospitalization program. This era saw a growing commitment to chaplaincy, exemplified by the goal of providing one chaplain—either staff or (CPE) student—to each inpatient unit. My assignment was to a single unit or treatment team, initially a locked unit of approximately twenty patients where the most acute psychiatric diagnoses were most prevalent. As a psychiatric chaplain, a variety of therapeutic approaches were utilized as part of the multidisciplinary team. These included individual and group therapy, crisis intervention, and family therapy. The chaplain was also responsible for providing spiritual care to patients and families, including pastoral counseling, support groups, and spiritual education. Communication with the interdisciplinary team was crucial to ensure that spiritual needs were met in the context of the patient's overall care.

How has chaplaincy to hospitalized psychiatric patients changed? This article offers the reflections of a chaplain whose career has spanned over thirty years in pastoral care ministry. Two different role models for chaplaincy, occurring in two different faith-based institutions, are described and the assets and liabilities of each identified. Four key changes in the delivery of psychiatric care are discussed along with the implications for the delivery of spiritual care.

The Reverend Roy F. Olson, DMin, BCC, serves as coordinator chaplain at Alexian Brothers Behavioral Health Hospital, Hoffman Estates, Illinois. He is endorsed by the Evangelical Lutheran Church in America (ELCA). roy.olson@abbhh.net
acutely ill were treated. Having no previous experience as a therapist and minimal CPE experience as a psychiatric chaplain, I began with the task of learning how to be a unit therapist and with the expectation that the role of chaplain would be integrated into the therapist role.

Both a once-a-week spirituality group and one-to-one patient visits were offered, dictated by opportunity (when patients were not in a unit activity) and patient interest. Looking back, it appears that therapist identity was primary and chaplaincy identity was secondary, for several reasons. The vast majority of my day was spent on the unit, where the primary concern was fulfilling the therapist role. I was a neophyte, finding my way into a new world of psychiatry, and later, addictions. All chaplains serving in psychiatry at that time were expected to be daily group therapy leaders.

The leadership team, composed of head nurse and psychologist, saw me as a new staff member who needed considerable training in psychiatric treatment in order to be useful to them. I was given the opportunity to enroll in a course in abnormal psychology at a community college and received careful weekly supervision and training. A social worker took me under her wing, initially coaching me in the leadership of activity group therapy with psychotic patients and later in a more verbal-oriented and less structured group therapy model. Gradually, I climbed the clinical credentialing ladder, eventually reaching the point of supervising other group therapists. In subsequent unit assignments, I also assumed a case manager role.

Multiple in-house educational opportunities were offered to staff, including weekly didactics, teaching interviews of patients and hospital-wide training seminars. The content of these rarely focused on anything overtly religious or spiritual, although occasionally more theologically based programs were offered at an affiliated pastoral counseling training center, which sought to integrate the spiritual and psychological dimensions of care.

On all the psychiatric and chemical dependency treatment teams, chaplains strove to be fully integrated into the treatment team, voicing the belief that their presence meant that when the subject of religion or spirituality arose from a patient contact in any group or individual conversation, the chaplain could immediately address it without referral to a person external to the treatment team. Chaplains in psychiatry were strongly influenced by their colleagues in chemical dependency treatment, uniting in a mission to introduce addiction treatment concepts of spirituality into treatment programs.¹

Initially, this was met with resistance from many psychiatrists and psychologists, who directly asserted or indirectly implied that any discussion of spirituality would cause the patients who were already psychotic to become more so. It was unclear whether this was their real concern or a red herring to hide their resistance to an incursion of religion into any psychiatric treatment. In retrospect, the philosophy and atmosphere of this treatment environment was very secular. There was little interest in applying religion or spirituality to patient care on the part of other treatment staff. Spirituality was not readily understood and was a term rarely used by patients outside of an addictions context.

The underlying approach that I took with respect to spirituality was to wed psychological concepts to spiritual topics, e.g., holism, anger, guilt-shame-forgiveness, grief and surrender, and to offer exercises/activities that would uncover patients’ values and priorities. Individual pastoral conversations often focused on whether suicide was unforgivable, confessions of guilt, theodicy questions and trying to sort out the real from the unreal in a world of delusions and hallucinations that often included religious content.

In spite of the chaplains’ strength in numbers, it now appears that the psychiatric chaplains—or at least this chaplain—were primarily learning how to do therapy. Second and paradoxically, chaplains were invested in what at times felt like a battle to make a place for spirituality in the treatment programs. It appeared that the battle was won—if not in the hearts of treatment staff—at least in the sense that a place for spirituality in unit programs was secured by the chaplain’s presence on the treatment team.

Chaplain as spiritual caregiver

Alexian Brothers Behavioral Health Hospital is a freestanding psychiatric hospital with eight inpatient units and nine partial hospitalization programs. Its commitment to chaplaincy, which arose out of the reality of a declining number of religious vocations serving in their hospitals and a directive by health system leadership to strengthen the spiritual dimension of care, continues to grow.

In this incarnation of psychiatric chaplaincy, my role is significantly
different and more narrowly defined. I was hired to be a spiritual caregiver, not any kind of therapist. A typical chaplain’s responsibilities include coverage of several inpatient units and partial-hospitalization programs including leadership of a total of seven to twelve spirituality groups per week. In contrast to my first experience, one-to-one patient visits occur with greater frequency. Topics and content of spirituality groups are not all that different from previous experience, though helping patients find their way through the thicket of guilt and bitterness to forgiveness has become a more central theme of the ministry. This focus has two significant dimensions: seeking forgiveness from those we have wronged and offering forgiveness to those who have wronged us.

When in the throes of emotional and mental illness, many patients who are persons of faith have difficulty accessing a loving, graceful, forgiving God because of unresolved guilt and shame issues left over from the early years of their religious training. Therefore guilt and shame, or more precisely, forgiveness, is often a core spiritual care issue in psychiatric chaplaincy. Patients face the legacy of the wrongs they have done and the unwillingness of others to forgive them. At the same time, they face the horrendous wrongs done to them, especially in childhood, as well as the task of extricating themselves from the pit of denial, resentment, bitterness, hate and revenge seeking.

There are at least two schools of thought on forgiveness. The first suggests that one should forgive for the sake of one’s own long-term mental health. The second suggests this method will not hold up over the long haul, that the underlying motivation to forgive must be altruistic and that the forgiver must develop empathy for the perpetrator in order to forgive. This view also distinguishes between forgiveness and reconciliation, the latter requiring the investment of both parties. I have elected to follow and teach this second pathway.

The initial focus of my assignment at Alexian concentrated primarily on further development of the spirituality groups: varying content and format, developing material for new topics and learning how to use the interactions within spirituality groups to identify those patients who are interested in or who may benefit from a one-to-one visit, especially those who may be at spiritual risk. The reality is that I have come to this assignment near the end of a career that includes previous psychiatric and psychological training and knowledge that is of great assistance in understanding patients’ concerns. Adding to that knowledge at this point is not my primary interest.

While I continue to be interested in the integration of psychological and spiritual approaches, my current focus is clearly on the spiritual side. I acknowledge, however, that colleagues who are in their first assignment as psychiatric chaplains may experience this same setting differently and may naturally seek greater knowledge of the psychiatric treatment issues they encounter in their clinical assignments.

I encourage staff members to identify and refer patients who may benefit from a chaplain’s visit, and they do so regularly. Some unit staff are invested in providing spiritual care, including those who perceive it to be a part of their role. Previously, the hospital was served by only one chaplain, who provided spiritual care training to selected staff so that they could lead spirituality groups as well. The heightened interest of staff in spiritual care raises some challenging questions.

What kind of control should the chaplain exercise over the spiritual care approach that other staff take in their one-to-one patient interactions? Beyond enforcement of a “no proselytizing” policy, how much farther should a chaplain go in monitoring or policing staff’s spiritual interactions with patients? Is it enough for the chaplain to provide inservice education? If a staff member tells patients that they won’t recover until they “get right with God,” does that fall into the category of forbidden proselytizing? May anyone be a self-appointed expert in spiritual matters?

A third model

In addition to the two models of psychiatric chaplaincy that emerge from my experience, there is a third possible role description for a chaplain who serves psychiatric and chemical dependency patients. This model more closely resembles the one-to-one pastoral visitation provided by chaplains on other hospital units. Such visits generally result from staff referrals or requests from patients or community clergy.

The treatment team usually does not see such conversations as connected to their work, and the content is more likely to be confined to overt religious needs. In these circumstances, it is the patients who have the primary responsibility of integrating
their spirituality or religious life into their treatment issues.

To what degree do the role differences described above differ because of the differences in the eras and contexts? Is the key difference the fact that one came at the beginning and one near the end of my career? The following is a discussion of the impact on my understanding and preferred choice of chaplaincy roles that has emerged out of the changes in hospital-based psychiatric care over the past thirty years.

**Significant decline in average length of stay**

In my first experience, a month was considered short-term treatment, and the inpatient program was designed to be a month-long psycho-educational experience. Very few patients moved on to partial hospitalization. For those who did, a two to three month stay was typical. Rarely was anyone admitted to partial hospitalization treatment without a prior inpatient stay.

My first entry into psychiatric chaplaincy initially was overwhelming for many reasons. Primarily it was due to the reality that there was a lot to learn about psychiatry, psychology and the therapist role, as well as how to overcome fears of relating to persons whose thought patterns were often strange and whose behavior was unpredictable, even threatening. I assumed that after my years of training and experience my return to psychiatric chaplaincy would be easy, smooth and not very traumatic. **Wrong!**

One erroneous assumption was that I would have the luxury of time to read and learn the patient’s story, including precipitating events and diagnosis, prior to making an initial visit. In my new context, the total population of the inpatient units and outpatient programs that a chaplain covers ranges from seventy-five to one hundred patients. Inpatient stays average slightly less than eight days.

When partial hospitalization programs began in the eighties, patients came for the full day (9 a.m. – 3 p.m.), Monday through Friday. Now some attend for half days and not necessarily all five days of the week. Length of stay in a partial hospitalization program averages ten days. This refers to the average number of days patients attend a full day. Either as an alternative or as a transition out of partial hospitalization, most patients attend intensive outpatient (IOP) or half-day treatment, which averages sixteen half days. These lengths of stay are partially attributable to patient need and partially to insurance coverage.

Experience to date suggests daily inpatient and weekly partial hospitalization turnover may be one-fourth to one-third of the inpatients. If a chaplain’s internal dynamics require a high level of mastery and competency for job satisfaction, such rapid turnover and resulting exposure to more than one hundred different patients on a weekly basis often is overwhelming.

The effect of shortened length of stay and rapid turnover on spirituality groups is that the focus must be on the content of the presentation. It is difficult to personalize any approach for individual patients. The inevitable conclusion is that most patients will have to make their own individual applications without specific guidance from the chaplain. Invitations are extended for follow-up individual visits and may result in conversations that day on an inpatient unit and within the week in a partial program.

In most units and programs, chaplains must operate out of the assumption that each visit may be the only visit they will have with that patient. Though each unit and program does treat an identified sub-group of patients, chaplains may not have the time to read individual stories or diagnoses prior to visiting. Thus, they must trust their listening and psychiatric assessment skills, make quick adjustments in their approach as they learn what the patient’s dynamics and issues are. Obviously, the highest priority is given to those patients who are at the highest spiritual risk.

My one-to-one visits have evolved into a somewhat routine format containing most or all of these elements: identification of the patient’s faith tradition if any, listening for and focusing primarily on spiritual issues, assessing whether the individual’s spirituality will be primarily an asset or a liability in their treatment/recovery, and offering a short-term concrete intervention or recommendation. I have found both Howard W. Stone and Duane R. Bidwell’s suggestions for short-term interventions to be helpful in this regard. When addiction issues are present, frequent reference is made to the spiritual aspects of twelve-step recovery programs to reinforce the interventions of other members of the treatment team.

Patient readmission is another aspect of the change in length of stay. In my first experience of psychiatric chaplaincy, the reaction to most readmissions was that the treatment team had somehow failed or that the patient had failed to follow through with their recommendations. In the second, while the total length...
of treatment for some persons may not be significantly shorter, it is more likely to be a series of shorter admissions, interspersed with attempts to make initially unsuccessful adjustments to live outside of the hospital. Although the milieu dynamics on the inpatient units changes daily, because a number of repeat admissions are included in the new admissions, I gradually became less overwhelmed by the turnover.

What are the implications of shorter stays for chaplaincy? The size of many of the spirituality groups and/or the rapid turnover prevent any significant personal applications. Though still operating out of the assumption that there will be only one opportunity for an individual visit, in some cases, issues that had been discussed during a previous admission may be revisited during a subsequent admission. Provided that the chaplain is assigned to work with the same population on both inpatient units and partial hospitalization programs, opportunities do arise for one-to-one follow-up visits and for continuing inpatient conversations. Further, some patient populations, e.g., eating disorder, continue to have extended length of stays that allow for ongoing one-to-one visits.

One final observation is that when patients request a visit directly or via staff referral, they often appear to grasp that the chaplain’s time is limited, that this may be the only opportunity for an individual visit, in some cases, issues that had been discussed during a previous admission may be revisited during a subsequent admission. Provided that the chaplain is assigned to work with the same population on both inpatient units and partial hospitalization programs, opportunities do arise for one-to-one follow-up visits and for continuing inpatient conversations. Further, some patient populations, e.g., eating disorder, continue to have extended length of stays that allow for ongoing one-to-one visits.

A final implication is that the completion of lengthy formal spiritual assessments does not appear to be practical or wise. Despite the wonderful thoroughness of the many models that are now available, by the time the assessment is completed, there would be little time left over for additional spiritual care. Psychiatric chaplains are required to complete increasingly complicated, JCAHO-mandated, hospital charting formats for all groups. This will become even more complex as hospitals pursue disease-specific certifications. Further, because such charting may impact the financial viability of chaplaincy, it is necessarily a high priority. When fifteen to twenty-five patients participate in Alexian spirituality groups, it has become necessary to create chart forms that can be completed in a short period of time. All these constraints necessitate writing succinct progress notes after one-on-one visits. Often these are actually mini spiritual assessments.

What will the future bring? Will computerized charting make these demands easier to meet? Will the average length of stay remain the same? Anecdotally, some psychiatrists predict that there will be a gradual increase.

**Treatment of the “dual-diagnosis” patient**

One of the profound frustrations of my first experience in psychiatric and substance abuse treatment settings was the unwillingness or inability of each treatment program to address what was beginning to be named the “dual diagnosis patient” and to integrate psychiatric and chemical dependency treatment. The strides made in this direction have been tremendous.

First, there is increased awareness that many persons with addictive disease also have a concurrent psychiatric illness requiring treatment. Secondly, alcohol or other chemical abuse needs to be assessed, and if present, addressed in all psychiatric patients. An addictions specialist may initiate contact with any patient, with or without an attending physician’s order. Thirdly, there seems to be a growing number—or perhaps a growing recognition—of persons whose pathway into addiction was paved through prescribed medications, especially opiates initiated following surgery and/or for other pain management. Finally, the understanding of dual diagnosis has moved beyond the simple psychiatry versus addiction and now includes the recognition that multiple treatments are necessary for increasingly complex diagnostic realities. Patients may now “cross-track,” that
is, receive more than one treatment regime at the same time.

The implications of this change for chaplaincy are that the concepts of chemical dependency spirituality, e.g., surrender, letting go, turning it over, guilt versus shame, God of your understanding or Higher Power, are now welcomed. Thus, they are more easily utilized by both staff and patients in many psychiatric treatment programs, easing the way for a greater acceptance of a prominent role for spiritual care in this environment.

Spirituality in psychiatric treatment

Today there is a much greater interest in and appreciation for the role of spirituality in the recovery process. From a thirty-year perspective, contemporary citations are frequent, rich and very supportive of spiritual care, and a few deserve to be mentioned here.

Marc Galanter writes:

It is reasonable to point out that our current psychiatric interventions may not fully utilize the transformative nature of spiritually oriented belief as an effective modality that can be employed for its clinical utility. Instead, spiritual renewal has come to be seen as separate from mainstream care, typically under the rubric of alternative and complementary medicine. It is these latter techniques that many ill people turn to in the face of technology-based medicine.8

Gary W. Hartz speaks to spiritual and mental health:

Recently, mental health professionals have become much more sympathetic to the importance of spirituality in the lives of their clients. In the past clinicians often ignored or worked around clients’ religious values. In the past decade the pendulum has swung in the opposite direction: many clinicians now have great enthusiasm for integrating spirituality into therapeutic work. One of the reasons for this swing is research showing that religious activity has positive associations with physical and mental health though these associations do not prove that religion causes better health. … However, the leaders also acknowledged the limits of our ability to change our circumstances and emotional states, which opened the door to clients’ using spirituality to accept what they cannot change.9

The professional journal Psychiatric Annals devoted an entire issue to the topic of spirituality in psychiatric care asserting that for providers of psychiatric care, competency in providing spiritual care is now expected.

The importance of understanding religious and spiritual problems and of developing effective treatment approaches is recognized as a core competency of psychiatric practice. … Psychiatrists and other mental health professionals [sic] increasingly are addressing religious and spiritual issues in their practice. Sensitivity to religious and spiritual issues is now an expected competency in psychiatric residency education programs.10

In my current experience, psychiatrists, psychologists and case managers frequently make referrals and express appreciation for chaplaincy visits and spirituality groups. Some staff members actively search for and refer patients whom they hope will benefit from a chaplain’s visit. The prominent role of spirituality groups as well as their frequency in the treatment schedule also testifies to this.

Yet questions linger. Is this prominence a reality in all psychiatric hospitals today, or is it present because Alexian is a faith-based hospital system and because of the commitment of top management personnel to strengthen spiritual care? Do staff members experience spiritual care as a welcome part of treatment or as an unwelcome imposition? While not really believing spirituality has a therapeutic role, do they acquiesce externally to the cultural climate of the institution? How many staff perceive what the chaplain does as a required religious add-on in a Catholic institution, as opposed to an integral part of the psycho-educational cognitive-behavioral treatment that is offered?

Cause of psychiatric illnesses

What causes psychiatric and addictive illness—nature or nurture—and what will be the future of psychiatry as it evolves in the direction of gene therapy and neuroscience? This long-standing debate pits the medical model of psychiatry against the psychodynamic approach of other therapies. Theologically, the argument has been expressed as determinism versus free will.

I asked a psychiatrist about the new discoveries in genetics and the apparent desire of many to reunite neurology and psychiatry that have been somewhat distant medical cousins for a long time. Specifically, what percent of dysfunctional
behavior and psychiatric disease is caused by flaws in nature and what percent is caused by flaws in nurture? The answer this psychiatrist gave was that the causation of dysfunctional behavior and illness was 80 percent nature. Even spirituality is being measured and researched today as a brain activity. The view of our hospital’s chief executive officer (CEO) is that any treatment not scientifically measurable will be increasingly suspect in psychiatry. It appears “neuroscience” will become the broad label for all the work being done with the human brain. Yet that same CEO places high value on spiritual care, publicly stating that chaplains and spiritual care are what make his hospital uniquely superior to others he has visited!

Conclusions

However the psychiatric chaplain’s role may be defined, the mission is to create a space in the various treatment programs where the spiritual dimension of patients’ lives may be addressed, to attempt to reactivate spirituality where it has been dormant, to introduce it where it has been absent, and to sustain and encourage it where it has been an active part of their lives. Some patients and staff may have difficulty grasping how or why the chaplain avoids lifting up one particular faith tradition and/or denomination as the most desirable one, understanding their own vocation as a spiritual calling based in their particular faith traditions.

There are unique opportunities and responsibilities that a chaplain faces in psychiatric settings. What role the chaplain chooses, or is given, strongly determines how these opportunities may be utilized and how the responsibilities will be met.

The psychiatric chaplain may function in a role that is primarily that of a therapist, including performance of some or all of the following tasks: leading group therapy, serving as a case manager, offering psycho-educational groups on various mental health topics selected by the entire treatment team, participating in psychodramas, offering family support groups or education, attending all team meetings and patient staffings, even becoming the team manager. The chaplain also may lead spirituality groups and offer one-to-one spiritual conversations with individual patients either by patient request or by taking the initiative. A hidden assumption is that the chaplain will integrate all that s/he does into this model, embracing it completely.

Depending upon how overtly spiritual or religious the content of the spirituality groups is, patients may or may not experience them as different from the other groups in which they participate. Likewise, to the degree the patients see the chaplain leading groups and doing case management in a manner that is not overtly spiritual, they probably will view the chaplain primarily as a therapist and may be less inclined to seek her or him out for spiritual conversations. Paradoxically, because they have more frequent contact with a chaplain who serves in a multiplicity of roles, they may be more likely to approach this chaplain. A deeper issue worthy of consideration is whether the patient’s transference is different if they see the chaplain primarily as a therapist or as a spiritual care provider.

Conversely, the psychiatric chaplain may serve primarily as a spiritual caregiver, offering spirituality groups on topics of the chaplain’s own choosing that may be more obviously religious or spiritual, while also setting aside more time for one-to-one pastoral conversations. In this role, the chaplain may use spirituality groups more intentionally to identify those patients who are at spiritual risk and make them a first priority. In this model, the chaplain may have more of a choice as to whether the spiritual care offered is fully integrated into the treatment model or whether it is a distinct, yet complementary, aspect of the patient’s overall treatment.

Training and experience as a therapist may contribute to a greater capacity for integration of spiritual care with the rest of a patient’s treatment. Understanding the processes of major mental illnesses and the fundamentals of treatment programs, especially the role of spirituality within twelve-step recovery groups and addiction treatment, may enable the chaplain to make a richer contribution to patient care and offers the potential for greater collaboration with other disciplines.

In a “whole person” treatment model that is foundational for spiritual care, integration of all dimensions of care is of high value, though the value attached to adding the spiritual dimension will vary. The additional training a psychiatric chaplain receives also will vary considerably depending upon whether s/he functions primarily as a therapist or as a spiritual caregiver. Still the question which began this discussion remains: to what degree is role choice influenced by whether...
or not the chaplain serves in a faith-based institution?

References


5. Resources for staff education include criteria for the provision of spiritual care by nonchaplain staff, a presentation by Laurel Burton, “Negative Indicators in Spiritual Care” at a workshop entitled “Who ‘Owns’ Spiritual Care: Opportunities and Responsibilities of the Healthcare Team” at the “Spirituality & Healing in Medicine” conference sponsored by Harvard Medical School (December 16-18, 2000). For ethical guidelines for social workers who intend to use spiritually based activities with clients, see Edward Canda and Leola Furman, Spiritual Diversity in Social Work Practice (New York: The Free Press, 1999), 260-8. For general guidelines for physicians, see Harold Koenig, Spirituality in Patient Care: Why, How, When and What (Philadelphia: Templeton Foundation Press, 2002). Each of these proscriptions suggests measuring patient need and interest as well as the adequacy of the provider’s training.


