

**The Stone that Was Rejected: An Exemplary Guide for the  
Psychiatric Institutional Chaplain  
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## Chapter One

### The Need for a Pastoral Model

#### Mental Illness Moving Toward Epidemic Proportions

Mental illness is reaching epidemic proportions. In the past twenty years, significant developments in pharmacology meant many new drugs were available to treat various forms of mental illness. A host of patients who had been lingering in institutions were able to leave the hospital and live in their communities. Yet the trend of de-institutionalization that immediately followed the development of these drugs has not been sustained. Rather the census of persons with mental illness across cultures and nations is growing at a profound rate, so much so that the World Council of Churches is pondering that mental illness could be the new frontier of ministry that revitalizes churches and congregations. (Tharyun P. et al., 2005) Another study suggested that the global mental health care situation appears dire, citing statistics that place mental illness among the top ten illnesses causing more than 37% disability worldwide. (Wang, et al., 2007)

The growing population inhabiting this planet, the shifts due to cultures embracing first world technology and values, the violence growing throughout the world and the growing disparity between persons of means and persons without resulting in a new apartheid of poverty, all combine to create an atmosphere in which more and more persons are succumbing to illness of the psyche. One psychiatrist, in writing about the response of young people to the growing complexity of the American culture suggested that, when faced with the level of expectations in the American culture for sustaining of life, many sensitive psyches were not able to function. (Shorto, 1999. p 11ff) Instead these persons let go of a connection to reality. His studies were especially focused on schizophrenia, which usually appears in the late teens or early twenties. In challenging his constituents, he named this manifestation a spiritual disease as much as a

biological issue. In his writings, he encouraged his own discipline of psychiatry to consider bringing in spiritual aspects to their practice.

However, as one other psychiatrist recently lamented, the medical discipline of psychiatry has moved in the opposite direction, primarily to a pharmaceutical approach. (Blazer, 2008) Blazer argues that the pharmacological practice of medicine, while perhaps alleviating symptoms of depression/mental illness, often makes persons spiritually worse. Blazer was joining Shorto in suggesting that psychologists and psychiatrists work with the spiritual self that persons bring to their treatment. Yet he did not address how such work was to be done by the psychiatric professionals. In essence, he raised a crucial issue but left a vacuum in its wake that begged the question of who might best approach this concern for the spiritual lives of the many who suffer from mental illness.

I will suggest that this vacuum, especially as it is encountered in state and federally funded psychiatric hospitals across the nation, is best filled through the role of chaplain. I will demonstrate the profound need for the role of chaplain<sup>1</sup>, yet also the lack of resources to guide that role in the psychiatric hospital. I will then provide one example of an integrated theory to serve as a foundation for the role of chaplain. Prior to this theory I will have clarified a methodology to present the theory as well as a pastoral model for viewing those with mental illness in the context of their life experience and an understanding for the way in which

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<sup>1</sup> To be a chaplain is to occupy a role. Because it's a role, it comes with boundaries of appropriate behavior. These boundaries create space for a respectful and caring presence, and also make the task more manageable for the person in that role. It is important that one's authentic being is connected to the role one plays, but also that the role and the person are not one and the same. The role is a tool, and one conduit for the self's expression. (see glossary)

spirituality and religion are connected and different. I will suggest by way of conclusions, a theological understanding and a process of formation to support the theory offered. Finally, I will suggest continued work that needs to be addressed in this area of endeavor.

The image offered in the title of this paper applies to the theory and the other areas of concern I am addressing throughout this work. It is ironic that mental illness itself, having resulted in such rejection due to stigma in our culture, could have potential for revitalization of ministry. If the World Council of Churches is correct that mental illness could be that which revitalizes the church's ministry, at the broadest level of consideration, mental illness becomes one image of the stone that was rejected becoming a central foundation (for that ministry). On a more individual level, those with mental illness who live in this world with fragile psyches and who experience rejection and isolation as a part of their illness often have a sensitivity to the immediacy of life that has a great deal to teach to this culture driven by so many external considerations. Finally, as will be shown throughout this dissertation, the role of chaplain, once rife in the psychiatric hospital, is greatly diminished in numbers over the past forty years. Yet in recent years, more and more evidence shows that a focus on spirituality most easily represented in the role of trained chaplain is central to the care of persons with mental illness. Finally, at the level of one's interior being, the "stone that was rejected", in the form of buried issues and symptoms can be of great help in attending at a soul level of care. At each of these levels, that which has been not valued is being reframed as that which can be of great potential worth.

### **Why Do We Need All These Chaplains?**

Recently, in a discussion about who to hire for a new state-run, 432-bed, mental health facility, one of the government employees in the meeting looked at a staffing chart and, seeing three chaplain positions, asked pointedly, "Why the hell do we need all these chaplains?"

Another person in the meeting replied in a rather tongue-in-cheek fashion, “Maybe if you were around more chaplains you would clean up your language.”

The director of the current mental health facility then said, “Actually, we couldn’t live without our chaplains. They do spirituality groups, they care for patients in a way that relieves the staff and meets a need, and they make assessments as to whether the religiosity evidenced by patients is normative or delusional. They care for all of us as staff when things happen in our lives.” Her list went on.

This verbal exchange points out in a cryptic way the challenge of describing the task of chaplaincy. Many assume that the sum total of the chaplain’s job description is delivering bibles and offering prayers, and maybe leading predictable services of worship. In other words, chaplains fulfill strictly religious functions that are about a stereotypical “saving souls and stomping out sin”. In the medical hospital, many believe the only purpose for chaplains is at the time of death. These unhelpful caricatures are derived from uneducated assumptions by people unaware of the depth of theory and integration possible for forming and training chaplains to offer spiritual care for those with mental illness.

The chaplains referred to above by the hospital director had extensive preparation in understanding their identity, the authority that was authentically derived from their training and personal integrative work, and their awareness of the needs that they could address throughout the institution. These chaplains, given their training and sense of pastoral identity and authority, in the face of religious projections and assumptions, had created a partial vision of what was possible in the hospital setting. Two further stories illustrate this need for Pastoral Psychology to

contribute resources for training and integration that allows for the development of chaplains working with person who have mental illness.<sup>2</sup>

### **Story One: The Pastoral Need in a Medical-Based Institution**

David was a chaplain resident, taking several units of Clinical Pastoral Education (CPE) to learn how to work with fragile persons. He wanted to move from parish pastor to chaplain. He received a referral to visit a patient, Vince, on a ward on the Acute Unit of the hospital. After introducing himself to Vince, David found a conference room on the ward for them to meet and the two sat down across a small table. David then offered Vince a space of time and opportunity for Vince to say whatever he needed to say. (In the realm of the state psychiatric hospital, this opportunity of time for the patient to articulate what she or he may want to say apart from any agenda of treatment is rare.) For some time, Vince didn't say anything. Then he spoke a couple of incoherent words. Noticing the intensity of Vince's struggle to speak, David didn't ask for a lot of clarification. Rather he nodded and offered a smile of encouragement. Vince spoke a few more words that began to form an idea, a generalized wondering of what was happening to him. David responded with the central felt experience he heard from Vince, acknowledging his confusion and frustration. After a few more minutes of David making assessments and responding accordingly, Vince, experiencing the safe-enough container offered by David, began speaking out his confusion of why he was in this hospital and then telling much of his recent story in a passionate way. In the midst of this story telling, a psychiatrist on the unit opened the door and stuck his head in and asked David, "Who are you?" David responded that he was a

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<sup>2</sup> All stories throughout this document will utilize initials or pseudonyms, but all represent actual events. All chaplain/patient encounters described are from the state hospital where I serve as chaplain unless otherwise specifically named.

chaplain. The doctor then asked, “What have you done to get this patient to talk? We have been trying to get him to talk to us for a week.”

This story points to the need for the discipline of pastoral psychology to provide resources for pastoral care to those with mental illness in the face of an institutional medical model that has a strong agenda thrust upon it of diagnosis and treatment. One psychiatrist, working on the acute unit, stated that their goal was discharge. They didn’t have time to offer much supportive care to patients. They were concerned that care from the chaplain could potentially cause a regression that would prevent them from being able to discharge the patient in a timely manner.<sup>3</sup>

In fact, another chaplain intern was asked by the staff not to continue to visit a patient who was struggling with issues of identity. They told her that because of her presence, the patient talked about these identity issues that were bothering him and they needed him to appear to be better so that they could discharge him. They admitted that he did need to talk about the issues he was bringing to the chaplain, but they didn’t want him to do that in the hospital because they needed to get the census down. In my nine years working in a state psychiatric hospital, I have

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<sup>3</sup> One particularly powerful example directly connecting with the issue raised through this chapter is from Elyn Saks, a professor of law and psychiatry who has suffered through schizophrenia. She was able to name the way in which medication alone as treatment utterly trumped her ability to have any sense of herself apart from the illness. She profoundly challenged a growing medical model mindset that says regression which happens as someone with a mental illness interacts with a caring other by way of talking about the issues and struggles is a negative thing. For her, it was her way to experience life in the midst of such a devastating disease. (Saks, 2007)

seen that this is not an isolated event. Because of this demanding task of diagnosis, treatment and discharge, especially at a time when many states were pushing their institutions toward downsizing, the various disciplines working with the patients did not have the time to offer a listening posture.

Returning to the initial story, on the face of it, David's 'pastoral intervention' was a simple thing. Yet he could offer this only because intentional development of self-awareness had been integrated with pastoral theory and best practices. Those entering this demanding pastoral role learn to consider several elements: the theological frame of reference that guides them; their personal history, including their unique experiences, as well as their cultural, ethnic, religious, etc. backgrounds that affects their current way of understanding; a body of knowledge from the behavioral sciences concerning both how persons develop and how relationships and communication affect personality; a depth of awareness of their immediate experience of feelings and meaning making; and a host of pastoral skills, including listening skills, spiritual assessment, pastoral assessment, relational dynamics, crisis theory and assessment, options of pastoral interventions, to name a few. All of these elements have the potential to allow for a depth of presence, for listening at many levels to what a patient is attempting to communicate and the possible pastoral need for care that lives behind that communication, doing so with little anxiety and an authentic acceptance. This educational process of integration suggests that the chaplain is best suited to bring a spiritual focus to join the medical model in a more holistic treatment for those suffering from mental illness.

### **Story Two: The Pastoral Need in the Face of Religious Agenda**

This story happened in connection with a church group who wanted to come into the hospital to offer ministry to patients on the Alcohol and Drug Abuse Treatment Center

(ADATC). Such organizations do not go through the pastoral care office, but through an office of Volunteer Services, found in most hospitals, that coordinates volunteer efforts. I received a call from Lucinda, the head of the Volunteer Services Department at the hospital where I work. This particular church group had come to offer ministry to patients in ADATC. They offered no encouragement or inspiration. Rather they exhorted patients to religious conversion as the only way to deal with their addiction. Some patients were quite confused, some angry. Others, mostly patients who had been through the rehab program several times before, had repeated a litany of repentance and new commitment to Jesus for salvation (i.e. from an assumption of hell) that gave no spiritual strength to stand in the face of their addiction. Instead, the submission to this process allowed a magical thinking about their addiction that actually stood in the way of their embracing the reality of their illness and the reality of the religious images living within them that could lead to recovery. Once the feelings from this sort of repentance disappeared, the patient returned to the drug of choice.

Lucinda asked me to help write up a policy she could offer to this and other church groups to clarify what they could and could not do if they came to the hospital. She sent the policy to this church. The church members, in turn, asked to meet with both of us. The meeting was held at their church. In the meeting, after a listening stance for their assumptions and concerns, I sought to explain why and how their way of ministry was not helpful to the patients. The minister said that they made no apology. They intended to bring their religious agenda, and they would continue to do so, no matter what. We had to say that they could not then come to the hospital. One woman then raised her voice in anger and told us we were going to hell.

This story reveals the other side of the coin, the other reason for the foundation of theory for the chaplain in offering pastoral care for persons with mental illness. The role of chaplain

serves to stand in the face of religious expectations brought by well-intentioned but unhelpful persons with specific religious dogma that insists on conversion to a specific set of strictures. These expectations are what the medical staff fear, even from the role of chaplain.<sup>4</sup>

### **Conclusions from these Stories**

These stories reveal a two-fold potent need from the discipline of Pastoral Psychology. The first is the need for chaplains with a strong sense of authentic and caring pastoral authority to hold their own in a world in which the medical model of treatment reigns supreme. The second need is for a theory of pastoral care sustaining to the human spirit in a world where a religious agenda of conversion focused on individual salvation from a conceived hell is confused with pastoral care. In other words, this second need is for clearly articulating the value of pastoral care while being equally clear that genuine pastoral care strongly rejects both agendas of conversion and anything that resembles invocation of divine punishment.

Integration of theory, emerging from and combined with integration of experience, creates a pastoral model for spiritual care. It allows chaplains to bring an unconditional positive regard to fragile folk. When they have been through enough of a process of personal integrative experience touching into the soul level of being, they bring the healing power of authentic communication. They can address a variety of spiritual needs that live in the relationship of psyche and soul. They have the theological training and background that allows them to hear and assess a variety of religious images and meanings that may be a part of a patient's experience. They can draw on a host of religious resources including knowledge of scriptures

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<sup>4</sup> This is not to disparage all evangelical theology. I have supervised persons who could offer a profound pastoral and encouraging message from that theological perspective without threat of hell or insistence on adherence to a particular framework of belief.

and use of sacrament that can connect in a supportive fashion with a given religious tradition or history. This understanding of the role of chaplain in the institutions that support their training has been developed over many years of history and integrative learning, sometimes as an oral tradition, passed along from supervisor to chaplain intern and resident. The following history of pastoral care and chaplaincy gives a greater understanding of this role of chaplain, how it was formed and the potential it holds, especially in the context of working with persons who suffer from mental illness.

## **A Brief History of the Chaplain's Role**

### **The Development of the Ministry of Pastoral Care**

Pastoral care began as a Christian ministry, distinct from other ministries (including evangelism), in the sixth century under Pope Gregory. (Hunter & Ramsey (Ed), p.838). His vision of what the church could be included the importance of soul care. He named four central aspects for care: nurturing, healing, sustaining, and guiding. Since that time, a stream of thought within the Christian tradition has reflected on what it means to care for an individual human's soul and spirit, in the midst of daily life or in the midst of crisis or loss. While I was raised in the Christian Faith, and the Anglican tradition, and while a large percentage of the patients in the state institution where I work identify as Christian, other religions are clarifying the pastoral role as well. Jewish, Buddhist, Muslim and other clergy are all articulating a similar focus and need for pastoral or spiritual care that is supported by a pastoral model, and theory that allows for a profound presence and spiritual care apart from theological agenda.

### **A Shift of Context: Pastoral Care or Behavioral Science?**

When the discipline of Psychiatry took a leap with Freud's positing of the unconscious in the early twentieth century, much of what was thought to be in the realm of religion and

addressed through ministers of the church was taken into the purview of the burgeoning behavioral sciences. In the wake of Freud's discovery of the unconscious the subsequent status of psychiatry was no longer a purely biological science. Such professionals in Psychiatry as Carl Jung, Victor Frankl, Melanie Klein, D. W. Winnicott, and others, began to reflect on spirituality along with the largely biological focus of treatment for those suffering from mental illness that continues to this day. Yet while these behavioral scientists saw religion as one means of meeting spiritual needs, because of the metaphysical and doctrinal nature of religious beliefs, the scientific community did not turn to the religious arena for any wisdom that could apply to the care of the human spirit. A sharp divide between things religious and the insights of spirituality in the psychiatric community deepened. (Pattison, 1978) This divide relegated any wisdom or perspective the centuries-old religious community might have offered to behavioral sciences to the specifically religious arena: church, synagogue or mosque.<sup>5</sup>

### **Religious Responses to the Widening Context for Spirituality**

In the United States, where religious freedom was guaranteed, the need for religious succor outside the walls of the church when persons found themselves confined in other institutions invited the growth of the ministry of chaplaincy. During this same time period of the early 20th century, the role of chaplain in the United States developed out of the Christian Church as a specific ministry of care for those in such institutions. This ministry was seen as a mission of the church to persons located in those institutions. Chaplaincy at this time was a role

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<sup>5</sup> Certainly the travesty of religious, especially Christian, doctrinal wars and persecutions in the middle ages, as well as the way in which the scientific community was treated at the hands of the church in those centuries provides a legacy of mistrust that could unconsciously taint the ongoing relationship between medicine and the religious community.

usually inspired by a Christian theology that held a doctrine of evangelism as a central tenet. These clergy perceived their ministry, along with the comfort of prayer, to be bringing as many individuals as possible into a “saving knowledge of Jesus Christ”. The doctrinal understanding emerging from this theological focus required an intellectual assent to belief in Jesus for the purpose of achieving individual salvation, again from an assumption of hell. The role of chaplain in the early decades of the past century, and the training for that role, focused on making sure that persons in the hospital, especially those who were in any danger of death, had the opportunity to assent to this doctrinal approach to salvation.

The main exceptions to this evangelical focus were the Roman Catholic chaplains who, rather than an intellectual positing of a God who required this assent to a specific belief system, brought a sacramental system to patients they considered to be members of their faith community. Neither of these expressions of religion addressed the deep pastoral and spiritual needs of psyche and soul.<sup>6</sup> In the wake of the ensuing methods of care in which psychology

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<sup>6</sup> This is not to disparage the power of the sacraments or of other familiar religious forms offered when people are sick. Yet when care is limited to these forms or sacraments, the psyche and soul needs can be ignored. In one pastoral situation in a medical hospital, a chaplain was present to a woman patient and her husband. In the presence of the listening chaplain, the patient began to speak of her fears and her sadness at her health limitations creating a need for surgery. At the first sign of her tears, the husband told the chaplain, who had brought the sacrament of communion, to go ahead with the ritual so that she wouldn't keep crying. Yet pastorally her tears began to help her process her grief and integrate the pain of the loss she was facing. This story is an example of how the sacraments or other rituals can be used to hide more than address pastoral needs (and the anxiety behind the dynamic of hiding).

addressed specific diagnoses of depression or other signs of a flagging spirit, and chaplains addressed the more theologically based norms of belief, a void was created for this central area of human need.

As time and theological reflection continued, religious leadership, including from some of the more evangelical religious communities came to realize that faithful and believing persons found themselves in challenging settings of life, time of loss and limitation that fostered struggles and need for support apart from doctrinal issues. Compassionate ministers in all traditions began to realize the need for resources to guide them in the offering of pastoral care. At the same time, continuing the dynamic began by the discovery of the unconscious, in the wake of theories developed in the area of the behavioral sciences, the focus of care that had previously been thought to be part of the purview of the religious world, grief and loss and the effects of crisis, were being studied by other disciplines. The therapeutic world was focusing on the human person and offering care in the midst of difficulties of life.

Religious communities seemed to have a couple of options in the face of this territorial shift. One option was for chaplains to cede trauma to the behavioral scientists and to move even more into an evangelical mode, seeing their main ministry as the “saving of souls” out of the earlier described doctrinal belief system, or applying some other ritualistic offering in the midst of illness. Hospitals, in appropriate response, were less willing to have their vulnerable patients subjected to such religious agenda. The other option for clergy was to receive training in the various psychological fields and become clinically trained ‘experts’. While these issues were being considered, some seasoned chaplains, often in the dual role of chaplain and of trained counselor, were developing a new formation process for seminarians. These students came to the clinical realm of the (initially psychiatric) hospital and began a process of integrating their

theological education with immediate hands-on experience of ministry for persons in critical circumstances.

### **A New Pastoral Training Ground/Method for Clergy**

In a psychiatric hospital, Anton Boisen, a pastor, recognized how uncomfortable many clergy were in the face of patients' real life experiences. (Boisen, 1946) Their seminary training formed them theologically and they emerged with a great deal of esoteric knowledge. But they learned little about how to be with people experiencing trauma or crisis, and they missed a soul-forming process of integration between theology and experience.<sup>7</sup> Boisen experienced this dynamic of awkward anxiety and lack of pastoral connection personally when he was forced from time to time to leave his pastoral role and be hospitalized for psychotic breaks. When back in his pastoral role, he invited seminarians to minister to the psychiatric patients in the hospital. He used a method developed by Dr. Richard Cabot, a mentor, to offer a structure for writing up their experience. He led these students in a process of working with these case studies of patients they visited in a pastoral role. He created a safe space, away from religious expectations, in which students could let their history and experience dialogue with their theological training. This more experiential approach of chaplaincy formation represents the beginnings of the process already referred to as CPE.

In the early and mid decades of the 20<sup>th</sup> century, Boisen held a vision of CPE as a program that could help integrate a theological mindset with the pastoral role and experience of working

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<sup>7</sup> Some seminaries recognized the lack in this focus on education. Episcopal Divinity School attempted a new plan in 1937 for training that would include significant clinical experience. The shift from a focus from religious academia to professional preparation was opposed and the attempt dropped. (Thornton, 1966)

with psychiatric patients. CPE became an organized program of training for religious professionals in the 1950s and early 60s. In reaction to the doctrinal focus of conversion described above, CPE training focused more and more on the behavioral sciences and a clinical approach that drew from a medical model of diagnosis and treatment for cure. Also, the program began to move into other healthcare settings, especially the medical setting focused on physical rather than mental illness.

### **Continued Religious Responses**

Interplay continued among perspectives of the religious institution, spiritual experiences of persons, and medical practice. The various seminaries of the day responded in a couple of ways. Many focused on demythologizing religion, and redacting scripture for historical accuracy; highly academic endeavors meant to lend credibility to the religious context. Others moved more solidly toward scripture as the absolute and inerrant authority for all things religious. Theological training became polarized between an evangelical focus on salvation from hell as the purpose for religion on the one hand, and the social gospel on the other. In the wake of these two polarized focuses for study, little energy was brought to the religious and spiritual needs of individuals, including those suffering from mental illness.

In the realm of the clinic (hospital, prison, etc.), when a religious agenda for such an understanding of salvation was cast aside, many other resources of religion disappeared as well. Training for chaplaincy began to focus on clinical skills and understanding of feelings. Chaplains read material by Freud and Carl Rogers. They were taught clinical psychological systems, instructed to adopt stances as mirrors for those in their care, and told to maintain

boundaries that were indicative of the therapist role.<sup>8</sup> They shied away from any attention to religious themes. (Gulko, 1983) Supervisors of this more integrative process were seeking to help form the clergy students through gaining more expertise in the area of behavioral sciences. Yet often the theories used by these supervisors were highly clinical in nature. Seminarians experienced a wide gap between these theories and the religious roles they assumed they would adopt. (Pattison, 1978 p. 126) Often, the methods employed in seeking to help students become more self-aware, created or re-enacted shaming experiences.<sup>9</sup> And some supervisors were less than supportive of any theological integration, having little respect for what they saw as outmoded belief systems. These early methods within the young program called CPE caused confusion among those being formed for ministry as either chaplain or parish pastor.

Actually, with the adopting of a clinical or medical model focus and method by the supervisors of the CPE pastoral training program, they were mimicking a parallel process going

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<sup>8</sup> I don't mean to disparage Carl Rogers and his most helpful stance of mirroring. While I have not used him in the theory in Chapter Four that I am building up to, his theory is one of my assumed foundations that allows for the kind of presence I will be inviting for the chaplain role. My distinction here is more about the difference in a clinical stance as different from a pastoral, and so usually more relational, posture, out of the pastoral model I will be inviting, as well as the freedom to listen for and consider spiritual and religious themes with patients.

<sup>9</sup> During the past fifteen years, when I have been amongst clergy in various contexts, once identified as a CPE supervisor, I have heard many painful stories of people from their CPE experience in which they remember little but these shaming and at times abusive or exploitive experiences. The potential for integrative learning had been sublimated under these sorts of pseudo-psychological processes.

on in psychiatry. One belief system was simply replaced with another. (Ulanov, 2003, p. 50) Psychologists and clinically trained clergy alike took Freud's system of thought and created a new ethic of behavior. This new ethic sought a naturalized basis, in distinction from the supernatural basis assumed to be the only possible warrant for Christian ethics. In actual practice, however, the "new ethic" merely substituted terms. Sin was replaced with neurosis that needed to be uncovered and addressed. Repentance was replaced with insight that leads to change. Obedience was replaced with compliance to the therapeutic process. The same underlying dualistic thinking that scientists charged was the problem with religion, was present in the form of a clinical approach to patients.<sup>10</sup>

### **Back to the Religious Training Grounds**

Returning to the wider world of Christian theological study, the academic search for historical accuracy, form criticism, or redaction in scripture gave way to the importance of the narrative of the scripture; what was trying to be communicated to a given community of faith.<sup>11</sup>

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<sup>10</sup> I acknowledge this is a sweeping statement. Many thoughtful people, psychologists and clergy alike, considered how to bring pastoral, theological, psychological and spiritual resources to the people in their care. But this general mood and way of thought must be named for the reality of experience it claimed for many clergy as they lived in this training ground.

<sup>11</sup> Brevard Childs, an Old Testament professor at Yale Divinity School was one of the earliest proponents of narrative theology. (Childs, 1989) The power of the narrative of the text for the community has become a theological grounding for the power of the life narrative of a person as a profound resource for pastoral and spiritual care. For those who know scripture, connection to the familiar images in narrative offer a meaningful resource. For others, different narratives from literature or fiction may provide that same connection of meaning making and community.

The focus on a doctrine of Salvation as escape from “hell”, or a social gospel gave way in many mainline seminaries to narrative theology. This shift to story occurred at two levels. One level was the embracing of the stories of scripture for the meaning and application they may have to life experience. The other level invited attention to the stories of a person’s life as a central resource for ministry. Liberation Theology posed questions about quality of life and introduced an image of God who stood with the marginalized and outcast. (Russell, 1993) Process theology, especially as described by Paul Tillich, invited an understanding of God in terms of being and becoming that emphasized a focus on personal growth. Jungian thought influenced understanding of the psychological and spiritual connection, invited a more spiritual focus for the psychological realm. Womanist and Feminist voices questioned a patriarchal method of theology that began with specific theological assumptions and belief systems, and in its place invited a new focus on experience, community and relationship.

### **Economic Issues Affecting the Contextual Confusion**

In the meantime, a shift occurred in the medical and psychological world as insurance companies began to limit payments for treatments they had formerly allowed. A more behavioral approach to treatment for severe and persistent mental illness as named by the DSM IV meant that many [of those in psychology and therapy] could no longer collect for extended on-going treatment, especially for persons recovering from grief and other spiritual needs. This shift in economics created a space in which theological and spiritual resources could be provided by chaplains and other clergy; now from a more integrated and educated place. However, it also

created a vacuum of chaplains. Many state institutions serving those with mental illness downsized chaplain positions in their psychiatric hospitals. Some eliminated them altogether.<sup>12</sup>

### **A More Sophisticated Model of Clinical Pastoral Training**

Drawing on more sophisticated theologies and theories, as well as the clear need for spiritual resources for ministry by chaplains and pastors, a more organized Clinical Pastoral Education required informed curricula of its supervisors to address the needs for pastoral education.<sup>13</sup> Such curricula provided opportunity for integrating the following: meaningful religious resources; one's own life narrative; relational skills; a welcoming stance for diversity; and the behavioral sciences. The curricula was created with a view toward helping a person in the role of chaplain claim a strong sense of pastoral identity and authority for the offering of that role in its own right as significant and important within the context of a clinical setting. (ACPE Standards, 2005, p. 10ff) Yet few of these new resources of supervision and training were found in hospitals treating those with mental illness.<sup>14</sup> Even staff in other medical institutions were

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<sup>12</sup> One example was the state of Georgia, who in the year, 1991, simply eliminated all such positions throughout their state psychiatric hospital systems. While no empirical data exists for measuring the outcome of such a move, again anecdotal experience can be offered in the form of a patient in one of these Georgia hospitals, a young lawyer, Philip, struggling with deep depression, who desperately wished for a spiritual presence in the form of a chaplain and lamented to a colleague of his the felt need and the lack of resource.

<sup>13</sup> Seward Hiltner, a well-known pastoral counselor, had suggested this as an important direction for the growing program of CPE back in 1975. (Hiltner, Seward, 1975, p. 98)

<sup>14</sup> Of the seven psychiatric hospitals in this country that currently have chaplains and advertise CPE (in contrast to the over 1000 programs in medical hospitals) (ACPE, 2008, Directory

leery of having any religious presence on their psychiatric wards.<sup>15</sup> Into this context of ministry with persons suffering from mental illness, Pastoral Psychology has the potential for provision at several levels.

### **A Pastoral Model to Stand Alongside the Medical Model**

A central purpose for providing the above history is to clarify and claim a specific and needed place for the role of chaplain for offering care to persons with severe and persistent mental illness, along with a foundation of theory inviting integration to support that role. This is especially important given that the medical model for treatment is the central focus for all disciplines of care, including pastoral care. Almost all people writing from an integrated perspective agree that the medical model's voice is the most powerful one in our culture today in considering treatment for those with mental illness. One prophetic voice addressing this imbalance is Swinton who said by way of lament in a recent symposium on working with the mentally ill, "The biomedical model has been given a pretty loud voice in our culture." (Swinton, 2007) The pastoral care department for one sister hospital treating the mentally ill has standards of care that are completely in line with a medical understanding of mental illness. (St. Elizabeth's Hospital, 2006) This model's focus on diagnosis and treatment for a specific outcome, usually for cure, creates an agenda for pastoral care that doesn't allow for a person-centered presence out of a pastoral model of assessment for care that attends to the fuller life narrative of the patient. In all hospitals, not only those for psychiatric treatment, Pastoral Care

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Section), only three of them (at the time of this writing) actually offer stipends for training resident chaplains. Three more are inconsistent in the programs they run for training chaplains.

<sup>15</sup> I served as chaplain for such units in two different medical hospitals, but the Department of Pastoral Care in each case had to work hard to have a chaplain presence allowed on these wards.

departments, seeking to defend their purpose and very existence to a hospital steeped in a medical model, are having to create measurable goals for care out of a diagnostic framework which are not as focused on the spiritual care possible from a pastoral model.

In a recent lecture series on medicine and spirituality at Duke University Medical Center (Blazer, 2007), a psychiatrist trained in the medical model spoke of the need for a shift in the medical perspective on treatment of depression. He acknowledged his interest in reading theologians who focus on narrative theology, and made a claim that it is in creating a space for a person's life narrative, along with the skills to help that person hear and make meaning in that narrative, that will touch at the core of depression, which he framed as a spiritual as well as physiological disease. Yet he lamented that the current billing practices simply do not allow for this kind of presence *by the institutional psychiatrist*.<sup>16</sup>

Part of this struggle with the medical model exists not only between disciplines, but also within the discipline of psychiatry. Back in 1981, an article lamented a scientific reductionism that was underlying the growing psychopharmacological movement in psychiatry. What was called a mind/brain division or dualism became a growing chasm. The focus of the 'brain' side

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<sup>16</sup> This is but one example of awareness that is beginning to sweep through the medical facilities. Caregivers and administrators alike are beginning to notice the failure to address the human need for what I am naming as a spiritual element of care. They are turning around and looking for where vision and training might occur for this. Given the religious nature of the role of chaplain, pastoral care is not a place they are prone to look for this vision and/or training. Yet this care and the integrative process for training has been utilized for decades in the formation and living into the role of pastoral care giver or chaplain.

of the division was on a biological/physiological understanding of the chemistry of brain function. In this understanding, the strong focus was on medication for treating mental illness. The focus of the ‘mind’ side of the equation was on addressing life issues. In a study done by John Perry in the mid-seventies, a residential house was set up for schizophrenic patients offering an “atmosphere supportive to the psychotic mental space” and a “psychotherapy which paid serious attention to the symbolism of patients’ delusional world.” (Perry, 1976 as cited in Reed, 1981) This represents the sort of approach that I am suggesting as a stance for ministry with those who have mental illness. Perry discovered that such a space allowed for the shift of psychotic symptoms within a few days, while also allowing the given person a sense of themselves apart from their illness. This was in contrast to the medicines that took weeks to build up in the bloodstream and then needed to be monitored for effectiveness. (Again, this is not to disparage all use of psycho-pharmacology. Medications have allowed many people, especially those suffering from bi-polar disease, to recover their lives. It is to point to the potential of a role that tends to the depths of the spirit.)

Yet current day practices continue to reveal the legacy of the mind/brain conflict. A previous clinical director of one state hospital sought to wipe out all psychosocial programming for patients and shifted the once mutual treatment teams into physician-led groups, the psychiatrist having the final say about all treatment which focused on pharmacology. At the Medicine and Spirituality Institute at Harvard University in December 2007, a few prophetic voices from the discipline of medicine called the medical community to recognize a reductionistic approach to treatment that was locked in a particular scientific mindset of statistical proof, even using the term “dogmatic” to describe this reductionistic approach *in medicine*. (Fitchett, 2007) The new word they suggested was “emergence”, including an

emerging spirituality. Yet what they were offering in support of that were myriads of scientific studies seeking to prove the case for spirituality.<sup>17</sup> In the face of such a reality, a pastoral model for spiritual care, supported by a foundation of theory that has a voice for the mind side of things, that draws on behavioral scientists and pastoral visionaries is a growing need in the offering of ministry to those with mental illness. As the Literature Review in the next chapter will demonstrate, while the “brain” focus of medicine has studied the effects of spiritual disciplines on the brain, little exists to serve as a foundation for ministry to those with mental illness from the perspective of the “mind”, including theory to guide approaches from those in a spiritual role.

### **The Pastoral Model in the Face of a Religious Expectation**

One reason that the role of pastoral care giver has not been seen as a resource for the purposes of this more holistic approach is the lack of legitimacy given to the religious nature of the role. The same dogmatic, reductionistic approach by religion has resulted in a similar dynamic to that described above existing in the realm of medicine. The initial story of the politician asking why so many chaplains (three) were needed for the over 500 patient population<sup>18</sup>, typifies this lack of legitimacy. At a continuing education forum I was asked to lead for social workers, a teaching on spiritual assessment, energetic conversation immediately followed. Many attendees expressed appreciation for the enrichment they received for their own

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<sup>17</sup> From my perspective, the workshop focusing on spirituality was years, maybe decades behind teachings in the religious arena of integration of spirituality as a way of training for chaplains from the CPE model.

<sup>18</sup> The original story spoke of the new hospital as having 432 beds. However, the large numbers of patients needing treatment forced the two older hospitals to remain open as well, raising the number of total beds.

spirits. Others expressed surprise. “I thought all y’all did was say prayers and deliver bibles. I had no idea you could do all this stuff and were guided by all this theory.”<sup>19</sup>

Some years ago, Gary Tiedeman who is a professor in the Dept. of Sociology at Oregon State University researched the issue of the relationship between chaplains and psychiatrists. He noted that this reticence to utilize the role of chaplain, regretted by chaplains, is often supported by psychiatric staff who have no education in the role of the chaplain. At the same time, he suggests “As medical science increases in sophistication, its temples of healing are reputed to become less psychologically comfortable for patients residing therein.” (Tiedeman, 1982) Again, at the Harvard consortium, the medical community was urged to recognize the role of CPE-trained chaplains as a central part of what the medical institutions have to offer by way of spiritual assessment and care. (Pulchalski, 2007)

Another reason for the lack of awareness of the potential for the chaplain role came from the dualistic approach by many traditions in the religious community. The same dynamic of “diagnosis for treatment and cure” also went on in the church for many centuries and is still going on in some religious traditions today in a way that has not proved helpful for the human spirit. Religious leaders who bring a dualistic system of belief to pastoral concerns, diagnosing the various ills in terms of adherence to specific religious rules of living can and have done great harm to the human spirit, not to mention the spiritual in all of creation.<sup>20</sup> And, while because of the specific belief system these religious traditions espouse, they claim to be standing apart from

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<sup>19</sup> Remark offered by CW, social worker at my institution.

<sup>20</sup> More will be said later about this issue of some religious agenda as it connects to the spiritual, but it needs to be named here as a central part of the problem that I am addressing.

the culture surrounding them, given the dynamics of a dualistic understanding, they are in fact, very much reflecting the very culture they propose to stand against. (Brueggemann, 1998)

Another reason for the relegated place of the chaplain in a religious role emerges from one dynamic of the church as an institution. The institutional church, again as a reflection of a cultural dynamic, can be highly reductionistic in its thinking. Much of the attention to the unique spirit residing in each person is then lost to larger issues. Religious persons with the best intentions have placed either conservative doctrine or large social issues ahead of the care for the unique human person and soul.<sup>21</sup> In a recent gathering of liberally-minded clergy, a quiet day for CPE supervisors in North Carolina, several lamented that they felt embarrassed to be in a role that immediately linked them with the cultural understanding of “Christian Values”, but one also lamented that her more liberal church bulletin only spoke of such meetings as ‘People against the death penalty’ or this or that environmental or political concern. Even though agreeing politically with all of the issues, she wondered what her church might also offer that would allow her to receive care for the depth of soul and spirit needs she experienced as a part of being human and living in such a stressful world.

One recent portrayal of the issues of loyalty to a religious system over spiritual health of the individual is seen in the documentary, “Jesus Camp”. (Ewing & Grady, 2006) In this movie, a politically and religiously conservative group fosters deep emotions in young people that they address first by a strong agenda of sin and repentance, and then by the paying of homage to

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<sup>21</sup> Edwin Freidman, who brought systems theory to the pastoral assessment of congregations, said prophetically that of the two central institutions for the care of the individual human, the therapeutic and the religious institutions, the religious institution was falling short and needed to bring much more depth and individual focus. (Friedman, 1993)

cardboard figures representing particular political figures and ideology (e.g. George Bush). In doing so they clearly appeared to be creating and grooming a loyal following for right wing political agendas and overlooking the pastoral concerns fostered through what looked like a manipulative or almost cult-like way of engendering specific religious agenda. One therapist who watched the film wondered about all the therapy these children would need in the wake of such experience.

Because of these religious agendas, pastoral leaders serving the church often misunderstand the role of chaplain. I once heard a parish pastor say to a group of chaplains that it is all well and good to have someone holding the hand of a person in the hospital as chaplain, but the church is preaching Jesus Christ without apology (not referring to the discipline of Apologetics!). Such a devaluing of the ministry of chaplaincy (and such a narrowing of the role of church pastor!) shows the dynamic that creates confusion at best and more often misunderstanding and disrespect.

### **One Foot In and One Foot Out: Chaplains and Institutions**

One Jungian analyst, James Hillman, attempted to demonstrate this dynamic of strong institutional focus taking precedence over care of the soul. He took a specific issue, suicide, and looked at various institutional disciplines of care: medicine, law, religion and sociology. (Hillman, 1993) Each of these approach suicide from a perspective that honors what Hillman called the ‘root metaphor’ of each tradition. Each of these root metaphors, by definition as well as by practice, excludes an understanding of the experience of the individual patient, which is essential in his thinking. (Hillman, 1993, p. 21)

The medical system’s primary agenda is to prolong life at all costs. The focus for the medical institution is on quantitative standards such as pulse rate, blood pressure, temperature,

etc. The stated concerns of the patient are tangential to the process.<sup>22</sup> In the psychiatric hospital setting, someone who has attempted suicide loses privacy, any level of personal choice, and any access to materials that could allow expression of writing, etc. They are watched all the time and made to sleep in a room with a bright light under constant surveillance. They are questioned and given forced medications to treat potential depression, ways of existence that define the treatment of criminals. They are dehumanized in the name of protecting human life.

The legal system's agenda is public safety. Again, life at all costs. Suicide is a crime against the state, against the preservation of the 'social contract'. In the 18<sup>th</sup> and 19<sup>th</sup> centuries in Europe, if a person tried to take her or his own life and was not successful, the legal system would punish with the death penalty. (Hannestad, 2005) In the wake of suicide, the English legal system considered the right to bestow property forfeit and took ownership of all the deceased possessions.

The religious system's agenda of life has behind it an agenda for control, whatever the motivation. The choosing of the time of one's own death is an affront to the creator of life. The religious institution is threatened by any lack of concern about how God might respond to such an act. If the church/God is seen to have so little control that one is allowed to decide the time of her or his death, then theological anarchy could follow. Hell is a controlling threat from the religious institution if a person chooses this route.

With the sociological discipline, the root metaphor is society and the focus is on the predicting of events, including suicide. These statistics are so predictable that factors causing

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<sup>22</sup> One doctor stated that most physicians are trained to make an initial diagnosis within eighteen seconds of seeing a patient and will follow their own hunch over a patient's spoken concern.

suicide are looked at apart from the individual. In fact, moving toward individual experience is a potential weakening or disintegrating of society and so to be avoided at all costs in any realm.

Hillman concludes that all of these institutions live in and reflect the reductionistic attitude of the culture that stands apart from the depth, complexity and subtlety of the individual human life.<sup>23</sup> None stands with the patient to understand what has so shut her or him down that living is too painful. None listens for an inkling of what does need to die in this patient that life could be possible. None gives space and humanity to someone in such deep psychic pain.<sup>24</sup>

Hillman, writing from the perspective of the Jungian Analyst, is challenging a less than personal way of relating he sees in the majority of the institutions focused on human concerns.<sup>25</sup>

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<sup>23</sup> I don't deny the need experienced behind this reductionistic way. Certainly the ability to care for the one in the midst of the many is much more complicated in this current day and culture. This information age has produced so much factual knowledge that systems are shifting to noticing dynamics over content. Yet this is a part of the reason why a role that is focused on the unique person within the given systems and dynamics and diagnoses of her or his life or symptoms is so crucial.

<sup>24</sup> Of course, Hillman is writing from the perspective of the Jungian analyst. Jung was highly concerned with the individual and with soul level and spiritual concerns. In part the theory from the behavioral sciences I will refer to in later chapters and that can help guide the chaplain is Jungian. I am not suggesting the role of chaplain holds the same qualifications as that of an analyst, but that the focus on the unique individual psyche and soul is the realm of what the chaplain offers, especially in these times when resources are so limited as in the state institution.

<sup>25</sup> In raising this strong voice regarding the reductionistic nature of these institutions, I am not meaning to discard any of them. We need institutions. They are full of people who desire to

What I am wanting to suggest is that, for the purposes of the state institution serving those with mental illness, the word ‘analyst’ in Hillman’s work be substituted by the word ‘chaplain’. As Hillman’s book title suggests, suicide is a matter of the soul. And few could argue that in our current managed care system, in which the insurance companies comply with the four disciplines named above, only a limited number, and certainly not persons in the state institution who suffer from mental illness, have the resources for making use of an analyst.<sup>26</sup> Nor does the lack of religious connection to the analyst make it a viable role for patients; a role that patients would consider helpful.

### **A Place for Pastoral Psychology and the Role of Chaplain**

What I am suggesting through this historical journey and this reflection on disciplines is that, given the integrity of the integrative role of chaplain as it has developed through history; and given depth of need for ministry with those suffering from mental illness, especially in the context of the psychiatric hospital, the discipline of Pastoral Psychology through the role of chaplain has a profound opportunity. It has the potential to powerfully impact the care of all persons with soul level needs, including those with mental illness; and to assist clergy and laity

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serve persons in need. As I will later clarify, the religious institution provides the possibility of a container for spirituality, provides a tradition that can nurture the soul, and that raises up and supports the possibility of staff who are trained in Pastoral Psychology.

<sup>26</sup> Interestingly enough, in many medical hospitals treating physical ailments, a chaplain is often an immediate referral in the face of a suicide attempt. But in the psychiatric hospital, the treatment team considers suicide business as usual and would seldom think to initiate a referral to the chaplain.

serving those in health care settings as well as the religious faithful in a pastoral role in the church.

Ann and Barry Ulanov wrote a pointed editorial applauding the Diagnostic Statistical Manuel, the manual that categorizes mental illnesses, for adding in a recent edition a specific paragraph that indicated patients might struggle with areas of religious or spiritual concern that is not an actual mental illness.<sup>27</sup> These areas focus on experiences of conversion or on questioning of faith or values. They are appreciating that, “Stresses felt in conversion experiences or loss of faith are recognized to exist in their own territory and not either to be magnified out of all proportion or dismissed as elements in a pathology.” In this article, the Ulanovs are revealing their frustration with the current trend by, what they call, “reductionists and bureaucrats of the psyche”. They are highlighting the complexity of humanity and the mystery of faith experience that cannot be explained by “mere enthusiasm” and that stands behind the need that I am addressing. (Ulanov, Ann & Barry, 1994, p. 105)

As will be noted in Chapter 2, many people, including thoughtful physicians and psychologists are recognizing that the medical model is not working for persons with mental illness. The model of diagnosis and treatment, especially treatment through pharmacology has created a shift from helping a person develop insight and coping, to helping that person feel better through the use of medication. (Maffly-Kipp, 2007).

In the wake of this growing recognition, the role of chaplain, sustained by the discipline of Pastoral Psychology is best poised for filling in the gap between medicine and the deep spiritual needs evoked by this illness. For the role of chaplain implies acceptance and allying with the other. It is this allying and acceptance that has been demonstrated to be most effective

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<sup>27</sup> Paragraph numbered V62.61.

in treatment of mental illness, both through personal narrative as will be noted in the literature review, and through documented study.

In one example of the latter, a Match Study (Project Match, 1993) looked at the various modes of treatment for addiction outside of the medical model. Such models as the 12 steps, insight therapy, motivation interview, cognitive behavioral therapy; over three hundred treatment modalities were studied. Findings demonstrated that all of the models worked about the same. No one model stood over another as more effective statistically. The one treatment factor that had a significant effect was the relationship between helper and patient. In other words, people got better depending on their ability to connect in the relationship, as identified by the client. Alliance was by far the best predictor of the outcome.

In some institutions, and certainly the public institutions serving those with mental illness, the chaplain or pastor is the only person with the ‘luxury’ of bringing this focus on alliance, of being able to stand present with another and create a container for an effective relationship. This luxury is not one of time for the chaplain/pastor. The small number of chaplains in any given institution means that most chaplains are stretched thin, are without the resources to bring their presence to as many as could benefit from it. The luxury is more one of not having a particular agenda of content, and so they are able to stand present to the soul-level need in the person before them. The training from the discipline of Pastoral Psychology invites presence that allows for this alliance, that fosters the creation of a container. This container allows for: appropriate intimacy rather than confrontation; spiritual presence over a faith-based approach; soul-searching as much as building pastoral care skills.

This chapter has been unfolding the development of and the clear need for the resources of Pastoral Psychology to support the role of chaplain in working with those having mental

illness (as well as hinting at the need for resources for all persons in pastoral leadership in other contexts). I am suggesting, as gleaned from the broad stroke of history above, that the role of chaplain is a role best inhabited by someone who has lived into a process of formation that includes a strong understanding of spirituality and religion. This understanding is comprised of having integrated experience as well as theory and theology at a profound level, of living and working out of a pastoral model of care that draws on that integration. The chaplain who is formed in this way, aware of anxiety that might challenge presence, can stand with the unique soul and spirit of a person and offer a profound level of presence. Neither of the dominant models, the medical model, or the religious model, is schooled in this posture of presence.

Unfortunately, as the following chapter will demonstrate, as the number of chaplains in psychiatric hospitals has diminished, so has the writing on the topic of pastoral and spiritual care for these persons with mental illness who have so few external or internal resources. Although many voices have arisen pointing to connections of medicine and spirituality, few of these voices and even fewer of the resources they name have permeated the context of state psychiatric institutions. As clinical pastoral training grounds have shifted to the arena of the physically ill, so have the academic works focused on spirituality, religion, medicine and ministry. My central purpose is to join early voices in promoting the role of chaplain in the psychiatric setting through a body of theory drawn from resources of human spirituality and of religion.

## Chapter Two

### Joining the Discussion: A Literature Review

My role in the state psychiatric hospital is both as a chaplain for persons with severe and chronic mental illness and the staff who serve these patients, as well as a Supervisor of chaplains in CPE. The patients in this hospital are there because they are deemed to be in danger; either they might harm themselves in some fashion, or they might harm another. They bring a host of differing symptoms that point to designated illnesses.

Perhaps the central thing I have learned about working with persons who suffer from chronic and persistent mental illness is that they are just like everyone else walking around outside of the confines of such hospitals, only more so. When I use this language, saying that those with mental illness are just like us only more so, I am living into a pastoral model of understanding. I am meaning to say that these patients, in the fact of their being, mirror back to each of us, perhaps in an exaggerated way, the dynamics that live in our own souls and psyches, some of our own deep needs that are crying out for visibility and a non-judgmental and caring presence. The pastoral model on which my use of theory is based is a way of spiritual care that recognizes the fuller life experience behind these needs as they live uniquely in each person.

One director at St. Elizabeth's Hospital for the mentally ill in Washington DC often used and perhaps coined the phrase, "the mentally ill are just like us, only more so". (Overholzer, W., 1989 as cited in Erickson et al., 1990 p. 156) She used the phrase in a very different way from the understanding I have suggested from a pastoral model. She was actually using the phrase as a warning, meaning by it that those with mental illness have exaggerated tendencies for negative kinds of behavior; suggesting that one needed to be wary and not allow a sentimentality of concern to take away a careful posture. The overall intention of the article and this director was

to request a greater commitment to ministry for persons with mental illness. The article lamented that few persons (either clergy or laity) had the expertise to be about helpful ministry with people suffering from mental illness. The article eventually suggested the potential of friendly relationships. This article, full of warnings and misgivings as it is, is one of the most optimistic writings of recent years inviting ministry among persons with mental illness.

In coming to this context for ministry over nine years ago, I quickly discovered that little has been written of late offering helpful theory that serves as a guide for ministry to those with mental illness. Certainly I don't mean to say that no material exists on ministry in this context or on mental illness per se, but much of the material is written from the perspective of a medical model. In my research for this current work, confirming this experience of a dearth of materials for this ministry, I searched six databases having potential for contributions. I looked at the following journals: the Journal of Pastoral Care: from 1959 through the current which comprises one hundred ninety four journals; the Journal of Pastoral Psychology, from 1980 to 2008 which comprises one hundred twelve journals; the Journal of Religion and Health from 1990 to 2008, and other journals that were offered through the data bases researched, as they were indicated to have articles that might be considered pertinent to this topic. While beyond my intended scope here, I also consulted various medical journals, out of interest. They confirmed the strong medical model of treatment for those deemed to have mental illness that relied not on the patient's experience, but on bio-medical measurements. In this chapter, I am reviewing several categories of the literature. The first category consists of models that touch on spirituality but that approach it from the mindset of the medical model. Following that are categories of literature that come from a pastoral perspective. Some I would deem historical; from the era described in Chapter One as highly clinical. Others are from something more akin to

a pastoral model, but without considerations of supportive theory. Finally are those contributing voices offering highly specified examples of ministry or need for ministry for those with mental illness. While these latter are meaningful, they are not offering the kind of foundational theory that can invite and support profound pastoral care to persons with severe and persistent mental illness.

## **Categories of Literature from a Medical Model**

### **Spiritual Disciplines and the Brain**

The first category from a medical view is that of medicine and spirituality, especially spirituality and the brain. Studies such as those conducted by Herbert Benson have looked at the results of certain spiritual activities on the brain, especially meditative activity. (Benson, 2007) These studies provide interesting research and they point to the efficacy of spiritual practices such as meditation or contemplation. Yet they are from a highly outcome-oriented focus indicative of the medical model. By that I mean that they are looking for a specific behavioral outcome, regardless of the felt need or personhood of a given patient. Perhaps more to the point, none of them examines open-ended narrative-based pastoral care as the independent variable.

Unfortunately, no studies specifically discussing effects on the brain have included mentally ill persons. When asked about the research on these spiritual techniques and mental illness at the December conference on Spirituality and Medicine, Benson said that he had not done any such research. He directed the questioner to Harold Koenig at Duke University. Koenig's research, which considers how those with mental illness see religion as beneficial to them, does not measure the effects of spiritual practice. (Koenig, 2005, p. 113ff)

### **Medical Research on Religion and Spirituality as Resource**

Other studies in the area of the relationship of religion and mental illness have demonstrated similar findings to Koenig. Research has revealed that a wide gap exists between patients who have mental illness and the doctors who treat them, regarding religious beliefs. (APA Report 10, 1975; Ragan, et al., 1980) While the APA has maintained that it is important for doctors to understand and attend to the religious orientation or beliefs of their patients, (APA, 1990), research in Switzerland has demonstrated that the opposite is likely to be true. (Huguelet, et al., 2006). This latter study revealed that a large percentage of those patients studied both found strong support in their religion and experienced strong conflict between their religious understanding and their physicians who prescribed treatment. As it connects to my theory this literature is not suggesting that physicians renege their role in treatment. Nor is it suggesting that patients (and their clergy) have the insight into mental illness to make good health decisions from their religious perspective. It is demonstrating a lack of understanding of the potential for religious or spiritual experience on the part of those treating persons and the challenge to spirituality and humanity presented by mental illness. This lack of understanding has been written about in more anecdotal ways as well as through these studies. (Eimer, 1989) One example cited refers to a patient with mental illness who was interviewed during his process of treatment, which lasted for several years. He had a completely different view of his best year over the course of this study than did his treatment team. In a medical measurement of desired outcomes from pharmacological intervention, his treatment team rated his best year as the one that the patient himself rated as his worst year. One of the years the medical team rated as his worst due to his apparent lack of cogent participation in his life in their estimation, was for the patient, a good year for reasons other than his illness. (Swinton, 2000, p. 35) While one can understand the reason for clinicians' suspicions about religion, ignoring a person's beliefs and

the values and experience they generate can complicate both illness and treatment; can add to the suffering brought about by mental illness.

While research substantiates the need for chaplains and religious services for those with mental illness, it does not point to any theoretical help in how to go about performing that role of chaplain. It does not suggest how to utilize theories of human spirituality, nor does it offer healthy ways of attending to the religious resources to aid those with mental illness. Even Benson's study is largely limited to the specific practice of meditative breathing. But such luxuries as biofeedback or other costly medical interventions to produce meditative states are not available to patients in state hospitals, making them moot for patients in this system and without resources.

### **Scientific Study of Physiology Standing Behind Spirituality**

While medicine does not focus on issues of religion and spirituality as a part of its discipline, speakers from the medical community, convinced of the importance of spirituality as it is connected to measurable physical outcomes such as brainwaves, have named a dualism they saw emerging from the medical model on the one hand, and the scientific model that stands behind medicine on the other. This dualism that sought to separate the spiritual from the material was addressed at the Harvard consortium noted above. Researchers were struggling with what they saw as a dogmatic approach from both disciplines of medicine and religion. This struggle was perhaps best modeled in the form of two speakers addressing what is currently being called a "bottom-up" approach to medicine and spirituality.

The first speaker, in an effort to shift away from the noted dualism, and claiming a post-modern approach, showed a scientific basis for spirituality, revealing the way in which the proven DNA process allows for change in the actual DNA of a person, depending on the way in

which that person is able to engage in spiritual practice. He ended his portion of the program by saying that we cannot see what is to come in human development as we continue to integrate the spiritual into our experience, that the path leads into the clouds where our vision cannot penetrate. He felt a freedom to allow for mystery in this area of ambiguity. (Clayton, 2007)

The speaker following him offered the same statistical information, but his conclusion was that once the scientific community figured out this DNA shift that we could use it as a way of addressing human illness and development. Although initially he claimed agreement in speaking from the same post-modern philosophical approach as his colleague, his conclusion was modernist: naming a certainty that we could one day through scientific, measurable means, figure out all the answers to questions we have not yet clarified and then those scientific answers would fix all human medical issues. (Huertas, 2007) It was a startling contrast, revealing the same struggle with dogma verses experience in medicine as lives in the religious institution.<sup>28</sup>

### **Descriptions of Mental Illnesses for Clergy**

Another category of literature offered by the medical community is the description of mental disorders written specifically for those in the role of minister. Ciarrocchi offers a helpful description of the disorders that ministers are likely to encounter. (Ciarrocchi, 1993) Yet in concluding each area of description, Ciarrocchi's description of how a pastoral care provider

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<sup>28</sup> In later discussion with the current director of my institution, he offered the notion of a positive dualism that exists in medicine and spirituality. This dualism is one that says both the medical model of understanding brain function, and a spiritual model that can bring spiritual meaning to that understanding live side by side. (S. Oxley, personal communication, May 12, 2008.) This understanding, while not written anywhere, underscores the theory of human spirituality I am using, and even the resources of theory from a religious approach.

might engage with a patient views the patient through the lens of the illness, rather than, as the pastoral model does, the person's humanity or fuller life narrative.

Another example of this category of literature is a book by Collins and Culbertson that describes disorders and offers case examples. Yet it has an emphasis on warning pastoral counselors and ministers about things they should not attempt to do. (Collins, G & Culbertson, T., 2003) While it is important not to "treat" mental illness when in a pastoral role, the authors do not address available theoretical bases for spiritual care from a pastoral model especially for those who suffer from mental illness.

One other category is the offering of practical forms of ministry. The renewed interest in spirituality groups generated articles such as one offered by a chaplain in a Catholic Hospital. (Smith, 2007) Spirituality groups are offered in response to the paradox of laws demanding person-centered treatment through programmatic means. So the "treatment mall" is a centralized manner of treating those with mental illness through a variety of groups that (usually) understaffed hospitals work hard to offer. The spirituality group cares for both the patients who experience an opportunity for a meaningful encounter and process, and for the beleaguered staff who appreciate the chaplain taking one of the slots in the demanding treatment mall schedule. The creative resources for leading spirituality groups in such articles as this one are helpful to chaplains who have a task of leading these groups. Yet they are but an outgrowth of the theoretical foundation that I am seeking to offer.

### **Theory not focused on Mental Illness**

Finally, some articles take certain resources that will be offered in Chapter Four as a part of the supportive theory, but don't apply that theory to the mentally ill. For example, an article written by a chaplain in a coronary care unit discussed the use of Victor Frankl's theory in

situations of intense physical illness. (Gojmerac-Leimer, 2005) A highly specific illustration from the Christian concept of resurrection is used by way of application in this case. While this article's focus demonstrating application of Frankl's material supports the way in which I will use Frankl's theory, the application itself differs from my work in two ways: the application is narrow rather than open-ended and it does not apply to persons suffering from mental illness.

### **Literature focusing on the Relationship between Psychiatry and Religion**

In the 1970s and the 1980s, the *Journal of Pastoral Psychology* offered several articles that focused on the relationship of psychology or psychiatry and religion. While one understanding of this relationship stands behind the theory offered in this dissertation, it is not my central focus. The journal *Pastoral Psychology* has offered much thought and theory on the issue of this relationship of disciplines, but seldom focused on ministry with persons who suffer from mental illness. The discussion of the relationship itself has not been a focus of much scholarly work in more recent years. Assumptions and considerations in this area of thought, while important, are beyond the scope of what I can deal with here in any depth. Suffice it to say that the relationship involves two distinct realms that focus on two areas of the human person. Certainly these two realms or disciplines meet and relate to each other, but the large focus on the medical model has made the conversation more muted of late.

One other area of contribution dealing with psychiatry and religion that comes from a theological understanding is represented by persons coming to the area of psychology with a specific belief system that suggest a given religious understanding is the way for healing of mental illness. Two different kinds of writing are a part of this field. One kind of writing is found in books that espouse pastoral counseling and chaplaincy as attending to issues and struggles of clientele of any kind by way of calling that person to adhere to a specific system of

belief and behavior. This approach will be eschewed throughout the theory I am offering. Another is the focus on how to respond specifically to the theme of the demonic, which appears so often as a religious theme for persons with mental illness. One significant example of the literature is represented by a series of articles in this area. (Southard & Southard, 1985/6) The focus in the word “demon” suggests an external entity of the demonic and ways of assessing the presence of that entity. (Southard & Southard, 1986, p. 133) Again, this is a different use of assessment than is a part of the theory offered. This issue of assessing religious considerations contained in delusion is addressed in Chapter Four, but not in the way offered in these dated articles.

### **Writing Inviting a Pastoral Vision**

More user-friendly in considering a pastoral model is John Swinton’s writing. He focuses on Pastoral Friendships (Swinton, 2000), largely addressing Christian Communities. His theology emphasizes the church’s vocation to ministry for those with mental illness. While his voice is vital, his focus is on the church rather than, as mine is, on the chaplain and supportive theory for the chaplain’s work. One of the things most helpful in Swinton’s work is his recognition that the medical model is not effective in what it intends to accomplish for those with mental illness. He quotes John S. Strauss, the professor of Psychiatry at Yale University:

“In the process of doing research interviews, conducting rounds and seeing patients in other contexts, it is increasingly striking to me how little I recognize in these people many of the key concepts that dominate the ways we as mental health professionals work. The things patients talk about and the way they talk do not seem to reflect our concepts, or at the very least, our concepts seem to reflect only such a very narrow range of what is going on in these people. (Strauss, 1992, as cited in Swinton, 2000, p. 34)

Yet, even with this recognition, Swinton’s chapter, “Beyond the Medical Model” looks primarily at the social contexts for those with mental illness rather than providing a pastoral model with

theory to aid the individual in the act of offering spiritual care to persons suffering from mental illness. (Swinton, 2000, p. 77ff)

## **Memoir**

Another important category is memoir. This material, focused on the individual, is most certainly a powerful narrative resource to begin to hear the devastation that this chronic disease brings for both patient and family. Several books have provided glimpses into experience as well as reflection on experience. Some of these memoirs are personal or family reflections, under the category of creative non-fiction. (Fast, 2004; Holman, 2003; Jamieson, 1995; Saks, 2007; Schiller, 1994; Styron, 1990) Others are meant to be specifically helping the mental health professional and focus on particular considerations for care of those with mental illness. Perhaps the most helpful in the latter category is *Fragile Connections* (Capps, 2005), which includes a chapter on Boisen. This category of memoir is an excellent resource for those in ministry who serve folks with mental illness. It allows one to hear issues and needs directly from persons suffering from this illness. While memoir does not provide the foundational theory that is the heart of what I am offering, it is a vital resource for a chaplain or pastor to learn about mental illness from those who suffer from it, or their families.

## **Supervisory Writing**

Another historic category, especially given the lack of current clinical pastoral training programs in psychiatric hospitals, is material from the perspective of the supervisor of chaplain interns and residents in the context of psychiatric hospitals. The main focus of this writing seems to center on translating “clinical” to mean clergy learning a medical model approach for ministry and not a pastoral model that seeks to bring spiritual care through a profound level of hospitality, inviting all of a patient’s life narrative. One central example is an article that

describes a student's work with a patient and the supervisor's subsequent work with the student. (Anderson, 1976) The patient was trying to communicate to the student. The supervisor, as he listened to this student recount the interaction, felt that the patient was somehow manipulating the student. The supervisor's intervention was to require a specific action by this student. That action was for the student to direct the patient toward a specific action or response. This parallel process; the supervisor controlling the student by requiring a given outcome, and then the student seeking to control the patient for some expected behavior or outcome; reflects how much the medical, outcome-based model was central for the pastoral milieu of that time. This example of historic supervisory literature reflects the opposite of the pastoral model and base of theory I am suggesting and that is lacking in the current medical system of care for those with mental illness.

### **Historical Institutional Literature**

In the fifties and sixties, when chaplaincy was a norm in psychiatric institutions and when CPE was still offered widely in those settings, chaplains regularly contributed, especially to the *Journal of Pastoral Care*. Between the years 1959 and 1968, this journal contained sixteen articles directly focused on ministry to persons with mental illness. (It also contained several articles on the relationship between psychology and religion, but seldom did these articles address the arena of mental illness.) By and large, these articles emerge from a medical model. Some are highly statistical. Others are more focused on specific symptoms of mental illness in a way that is meant to be educational for pastors. I found myself curious about the motivations behind these articles, and whether they were in part attempts to communicate to the medical community the awareness by these clergy of medical interventions and behavioral sciences.

## **Offerings that Touch on a Pastoral Vantage Point**

Other recent contributions in the specific area of theory to support pastoral care for those with mental illness are found in the *Journal of Pastoral Care* and originate from the vantage point of the behavioral sciences. Academic works that bring theoretical and theological resources to bear for ministry to those with mental illness are rare indeed. Even in the *Journal for Pastoral Psychology*, over the past thirty years, it was rare to find articles that addressed the specific needs of those with severe and persistent mental illness.

A couple of exceptions to the lack of articles containing theory for pastoral care for those with mental illness do exist. One is an article on the spirituality of self-mutilation written by Heather Pinks. (Pinks, 2003) In this article, by way of explaining how mutilation is a spiritual issue, Pinks briefly studies the sacrificial theme in the Hebrew Scriptures. She then looks to the New Testament understanding of Jesus' martyrdom and the subsequent view of the benefits of self-mutilation in the Middle Ages held by the church. Although in the beginning of her conclusion she asks a dualistic question of the goodness or badness of self-mutilation, she winds up the article by shifting to a less dualistic stance, realizing the importance of noticing the voice of spiritual need living behind the mutilation, a stance that I will support theoretically.

This is a meaningful article offered from a perspective of the discipline of religion and spirituality under-girded by knowledge of the behavioral sciences. Although not quoting voices from the behavioral sciences, clearly the author is aware of and stands with behavioral scientists who look more to the present for meaning and possibility, and less to the past for etiology of a given manifestation of mental illness. This article is one example of a larger picture I hope to portray about the role of chaplain in working with those having mental illness. A larger context of theory for the role of the chaplain in working with persons suffering from mental illness will

give a map in which to then place and use such articles as this one, considering how to apply the larger theory to a given specific issue.

One other article inviting a vision for the care of those with mental illness was written by Steward Govig (Govig, 1993). This sensitive article focused on pastoral support for the families of persons with chronic mental illness. Govig utilized questionnaires to assess the experience of those with mental illness and their families across the country. He wanted to find out how helpful any religious figures had been in their experiences. He learned that for the most part, families were hurt and angry at the lack of educated or helpful response from clergy, pastors and chaplains alike. He recommended courses that focused on care of persons with mental illness as well as their families. Dr. Govig, in the face of the need he discovered for pastoral care for those with mental illness and their families, called for visibility and care for this population with fragile psyches and the weary family members. In the face of this devastating disease, he lamented the lack of courses designed to help clergy offer ministry with those having mental illness and their families.

Supporting Govig's findings concerning the lack of understanding by clergy were studies that showed that the number of people with mental illness who would consider going to their clergy had fallen significantly over the past couple of decades. (Burton, et al., 1996, p. 11)

### **Offerings from the Church**

As noted already, Swinton has issued a strong prophetic call to the church to be about ministry to and for persons with mental illness. His is not the only voice inviting this initiative. The World Council of Churches as stated in the opening paragraph has a strong concern for persons with mental illness. In Chicago, an Episcopal Church has a strong ministry focused on mental illness. One interfaith group has pulled together, from various denominations and faith

groups, impressive resources and ideas focusing on issues of stigmatizing, housing, healthcare and the like. (Pathways, 2008) These are vital resources for persons to approach cultural blocks and provide structure to address issues affecting those suffering from mental illness. Yet they do not address the need for theory that supports the individual offering immediate pastoral care.

### **Rekindling a Powerful Vision**

The vision that initially emerged for this educated and integrated role of chaplain who could offer ministry to persons with mental illness is not new. I am joining an idea and a conversation that was espoused by visionaries living in the early 20<sup>th</sup> Century. Helen Flanders Dunbar, a psychiatrist who also had a theological degree, offered a strong voice insisting that spirituality be recognized as a resource for persons suffering from mental illness. Anton Boisen was a pastor who also experienced psychotic breaks. When free from symptoms of his mental illness he was a powerful visionary in promoting an ideal of treatment for those with mental illness that included spiritual resources along with medical interventions. Both of these voices rang out a clarion call in the early decades of the 20<sup>th</sup> Century for a vision of a pastoral framework and presence that complemented a medical model.

Dunbar writes,

“The priest speaks first of goal, the spiritual, that which maintains health and wholeness and brings promise of external assistance.” In contrast, without promising any such ‘reinforcing of strength,’ the general physician tries to set the soul at ease by removing ‘objects in the patient’s path,’ and the trained psychiatrist focuses on ‘straightening out disharmony’ in the patient’s path itself. Religion alone, she suggested, could add spiritual confidence - as in, “The Lord is my Shepherd”, or “Shema Israel!” – to the soulful contentment and calming effect that either religion or medicine might achieve. Clergy and physicians both could focus more on the present as it unfolds into the future, i.e. on prevention, with less emphasis on the past, i.e. on the etiology of an illness or disease. Together, the psychiatrist, the physician,

and the pastor might guide the person seeking help toward becoming emotionally, soulfully and spiritually free to think and act.” (qtd in Powell, 2001, p. 99)

Dunbar’s recognition of the importance of a pastoral model and of collaboration between chaplain and psychiatrist is foundational for this dissertation.

Congruent with Dunbar’s vision and bringing practical theory and approach for the training of pastors that would allow her vision to be realized was Boisen’s insistence on an integrative model of learning that encouraged experience to affect academic learning. He issued a prophetic invitation to study the ‘living human document,’ generating response and action by those who recognized the need for such integrative learning. Boisen had a dream that one day ministers would be able to enter the world of those with mental illness, a day when, “specialists in religion would be able to go down to the depths of the grim abyss after those...in whom some better self is seeking to come to birth.” (Reed, 1981, p.8)

The combined visions of Boisen and Dunbar generated great interest in many who came after them. At one level, their mutual dreams have provided powerful results, namely CPE as well as parish clergy who are attuned to the deeply felt spiritual needs of persons. At another level, their vision of psychiatrists and clergy working mutually with patients continues, in large measure, to lie dormant. This vision has dwindled to a few remaining chaplains scattered here and there in psychiatric hospitals.

While interest in Boisen as a historical figure remains high<sup>29</sup> the clinical training program he initiated for clergy has moved largely, almost exclusively, into the realm of acute care hospitals treating physical illness or injury, and away from its initial context of the psychiatric

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<sup>29</sup> For example, a current day practitioner is seeking to diagnose Boisen’s specific mental illness anew. (North, 1981).

hospital. Although Swinton has proposed to the church the creation of a role of Community Mental Health Chaplain, (Swinton, 2000, 151) few models exist in the church for specific ministries among those with mental illness. Precious few psychiatric hospitals currently provide CPE programs. As I've noted elsewhere, even the three or four who purport to offer residency training seldom actually are funded to hire (and train) resident chaplains.

This dissertation will update, expand upon, modify and integrate Dunbar and Boisen's work. It is my hope to stand in this legacy and offer a vision for one possibility of an integrative process, drawing from narrative and from the perspective of Pastoral Psychology, that can call forth awareness and potential for a host of chaplains who have training in integrating theology and the behavioral sciences, who have experience in working with these people with fragile psyches, who are able to bring a hospitable space to those suffering from mental illness, coming alongside them with a non-judgmental presence and profound level of acceptance.

## Chapter Three

### Methods and Descriptions

#### An Overall Statement of Methodology

This chapter is focused on the methodology I will use; a methodology that is consistent with the integrative and narrative based pastoral model I am espousing. As named in the first chapter, pastoral care departments throughout the country are being asked to demonstrate their usefulness by means of statistical analysis, based on a diagnostic medical model of understanding. This insistence on a pre-determined outcome-oriented approach to pastoral effectiveness is an example of a reductionistic approach by the culture in general to the highly complex and subtle experience of being human. It stands in the face of any understanding of a pastoral model of approach that utilizes a profound listening presence and spiritual and pastoral assessment for care to the unique psyche, soul and spirit of a person.

In saying this, I don't mean to suggest that one cannot in any way seek to determine how the pastoral model of spiritual care impacts persons. Certainly, marketing questionnaires that focus on patient satisfaction can support the chaplain role well, although any focus on the chaplain is seldom used for those with mental illness and not in the state institution where I serve. Recently at a local hospice, a survey asked clients how they experienced the care of the hospice team. Comments at the end showed that the high rating was largely due to the patient and family's appreciation for the ministry of chaplains who were operating out of an intentional pastoral model for spiritual care; present to the experience and inner world of the patients and their grieving families. (Duke Hospice, 2007)

But such diagnostic testing as period of recovery, physical evidence of change in recovery, etc, all measurable medical goals, while possible indicators of the impact of pastoral

care, cannot be scientifically established in line with a medical model to prove the connection of recovery to pastoral care. As noted in the last chapter, in the annals of medicine and spirituality, great evidence exists for the power of the spiritual in the process of recovery, but these are focused on specific outcomes, not on the pastoral need as articulated by a given individual.

Some persons, given the presence of a chaplain, may utilize their spiritual or religious resources for a shorter period of stay (a goal derived from the complicated financial system of managed care). Yet a pastoral concern may suggest that the opposite is better for a given patient, a longer stay would afford time and space to address pastoral or spiritual issues that, if ignored, may trigger a return of the illness. This benefit of spiritual care is not measured by any medical standard. Narratives of people lamenting historical experience are often heard by the chaplain and could perhaps be gathered up into measurement. But to have a sustained study that could account for all the variables demanded of a medical model would be exceedingly difficult, if possible, and would be denigrating to the pastoral model I am inviting.

As noted in the Literature Review, the medical community is voicing some struggle and tension within its own ranks about the highly scientific approach to collecting data and proving assumptions not easily measurable. The tension is so strong, that a presenter at the Harvard Conference referenced earlier was using this means of measurement to attempt to demonstrate the need for not always assuming such means are helpful or accurate. (Fitchett, 2007) A central issue in this realm of statistical scientific data is that it provides data demonstrating things that have been obvious to other “softer” sciences, sometimes for decades, sometimes for centuries. Most obvious is the example of the evidence that meditation was beneficial to humans. The dogmatic need for scientific data that has bled into other disciplines in the hospital setting has led to a void of depth, perhaps what we might call “soul” in the context of medical institutions.

This dynamic in medical study was so impersonal that the Harvard Medical Conference pleaded with physicians to use general techniques of kindness as a way of beginning to implement the spiritual in medical care; such things as sitting down to speak with a patient rather than standing with one hand on the door knob. They were trying to suggest that statistical data and measurable physical norms of temperature and blood pressure were not the central need in many situations. This is not to say that measurable data for medical interventions is not a good and necessary thing, nor is it reductionistic in and of itself. It is rather saying that to limit all other studies to this same measurable means can stand in the way of rendering the service intended.

For this reason, the methodology I am utilizing, in order to stay true to the very integrative and experiential pastoral model being articulated, must be anecdotal, based on narrative, and be generated by experience as a trusted guide and resource. In this way, I will model the narrative grounding of the pastoral approach for which I argue. Supportive theory is central to any such task and will be employed, but only as it has proven through experience to be useful to the offering of pastoral care for those with mental illness. The following are more specific methodologies, resources, and explanations of process, including a pastoral model for understanding mental illness as well as a discussion on the relationship between spirituality and religion.

### **Resources of Spirit Different From and Connected to Religion**

The first part of Chapter Four will consider spirituality apart from any given religion. Throughout the history of psychology and psychiatry, a few in each of these fields have believed spirituality to be a profoundly important resource for persons seeking to recover from or live with mental illness. In the same way, others in these two disciplines have believed it to be of no

consequence, have avoided or even resented anything to do with this focus of spirituality. In my experience, a couple of main reasons exist for this latter resistance. One reason is how quickly spirituality leads to a religious focus on that which is metaphysical or supernatural. Another is the history of the practitioner who had negative experiences with religion her or himself. Yet for many in the history of these two disciplines, notably Jung, Winnecott, Frankl, and others who inherited their legacies, as well as many compassionate psychologists and psychiatrists working with individuals suffering from mental illness today, spirituality is an absolutely necessary experience of the human person. So in this first part of Chapter Four an understanding of the human spirit will be more specifically conceptualized apart from religious language or constructs. Supportive theory integrated from behavioral science that allows the chaplain to bring presence and awareness to this profound area of humanity will be offered, illuminated by anecdotes that ground the theory.

While having an understanding of human spirituality apart from religion is vital, few in this culture have no connection to religious images or understandings. If one is to serve in the role of chaplain for persons with mental illness, an ability to make assessments of how a person participates in religion or in any religious endeavor is essential, as is having the background of a theoretical basis for such assessment. The second part of this chapter offers one example of that supportive theory when religious images apply, or when religious endeavors become apparent, even if not specifically named. Again, the central method for this chapter is description of theory and anecdotal illustration.

### **Theology and Formation to Support the Theory**

In Chapter Five, two major conclusions are drawn in the wake of the theory offered in Chapter Four. First, in order to be about ministry while inhabiting any role deemed religious, a

person must be aware of the theological framework that supports that role. Otherwise, that person is doing one of two things. Either that person is assuming her or his framework to be, not a framework, but the one correct theology. Or that person has but is not aware of the theology that, in fact, does guide him or her. The theology offered in Chapter Five underscores a central need for accepting diversity and differences, and for any specific religious agenda to be set aside as an *a priori* expectation. This is a difficult tension for the chaplain to hold; having a foundation theology of support as separate from bringing a theological or religious agenda to a patient or client. Even in the most experienced of chaplains, at times the slim, if vital, difference can be lost.

Attending to this tension between standing on a supportive theological foundation while present with a patient on the one hand, and having a theological or religious expectation for a patient on the other is one of the central theological tasks of the chaplain. Tangential to it, however, is also the task of having enough openness and awareness to allow for a theology to be built in the midst of the pastoral encounter, so that in the pastoral relationship a theology for the immediate encounter is created between pastor and patient. This is not necessarily a conscious or named process, yet it is a respectful process, giving space for a mutual visibility of both.

In addition to a theological stance, three theological (and ultimately pastoral) concerns important to the pastoral task are also named and described. These concerns include morality, salvation and scripture congruent with the theory espoused. Although noted by way of conclusion, these concerns both invite and support the theory in Chapter Four.

The second conclusion drawn in Chapter Five is that in order to be about ministry in a role of chaplain, a process of formation that is congruent with the theory (and therefore the theology) supporting the ministry is necessary. Some central considerations for the process of

formation for the role of chaplain are described in the wake of this explanation of theology.

Again the methodology for Chapter Five, along with being descriptive of these two central points of conclusion, will be highly anecdotal, describing the process of experience and reflection for these persons educated as pastor in the context of working with those suffering from mental illness.

### **Initial Theory About Mental Illness to Support the Methodology**

The theory and theology offered in the following chapters is based on a pastoral model for describing those with mental illness, looking at their life narratives and common experiences. It is also based on an understanding of the relationship between spirituality and religion helpful in working with persons with mental illness. So concluding this chapter is first a description of mental illness from this pastoral model as well as characteristics often found in persons suffering from mental illness. Following that is a brief look at one view of the relationship between spirituality and religion as it relates to this ministry.

### **Mental Illness from a Pastoral Perspective**

The DSM IV (DSM IV, 2000) is the authoritative word, the “scriptures” for the medical model of mental illness. It describes the symptoms that constellate a condition considered treatable and billable in the eyes of the insurance companies. While it can be helpful for a chaplain to know and understand these symptoms and conditions, speaking of mental illness from the perspective of pastoral psychology is quite different from the symptomatic focus of the DSM IV. This pastoral perspective and intervention is a powerful complement to the value and aid of medical and pharmaceutical interventions for those with mental illness.<sup>30</sup>

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<sup>30</sup> One physician in my institution suggested to a group of CPE interns that, “You can’t hurt these patients no matter what you do, if you are approaching them with openness and good

The following are several frames for viewing mental illness from a pastoral perspective, as well as assessing persons with mental illness from that pastoral perspective.

### **A Conceptual Frame**

The first frame considered here clarifies that mental illness is not an all or nothing experience, rather mental health lives on a continuum. Given that persons with mental illness are often defined by their illness, the concept of a continuum of mental health gives a needed balance to the stereotypes placed on such persons. Pastors will encounter all sorts of people who are struggling with the same symptoms as those who have been deemed to have mental illness, but on a less intensive scale. The continuum is laid out here.

Wholeness-----Extreme sickness

None of us lives utterly at the extreme of wholeness. All of us have times when our sense of stability is challenged by experience; times when we struggle with our identity or with despondency. In fact, these struggles, the fact that we are not whole beings but live in this world

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intention. You can't say the wrong thing. They are so wounded that any intention for their care, any listening presence that you might offer can only be of service to them." This was in reply to anxious questions asked by the interns after listening to descriptions of the various categories and symptoms of mental illness. This physician was a deeply spiritual man of the Jewish faith. He left the institution soon after, frustrated at the way the medical model was being applied. He was one who invited the chaplain to stand elbow to elbow with the physician in working with the patients. He had a stance that offered a deeper sense of humanity to these patients.

with needs, are part of what cause us to become involved in the world and in relationship. Awareness of these needs and engagement with them, rather than denial, offers the possibility of living more toward the side of wholeness. Many who struggle with mental illness have been overwhelmed by needs that remained invisible, were ignored or even shamed. So from a pastoral perspective, understanding the challenges to stability and identity, whether from some external experience as the death of a loved one or from a specific physiological condition in the brain, is a central focus for care.

This continuum helps the person in the pastoral role both with triage and with pastoral assessment. For instance, if the symptoms of mental illness become such that they interfere with living life in any manner of normalcy as defined by the person her or himself, medical intervention may be helpful along with pastoral presence.<sup>31</sup> Or when a person's reality no longer matches the reality of others, medical intervention is almost a necessity.<sup>32</sup> For example, if a person hears voices that others don't hear or sees images others don't see, then treatment within the medical model becomes necessary. These two indicators of need for triage are ones that indicate relatively severe and possibly chronic mental illness. Yet given the limitations by insurance companies, many don't receive treatment at these points of great need unless direct

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<sup>31</sup> If those symptoms are due to an external source, such as a painful loss or crisis that is different from a chronic condition, this may point to a need for strong support instead of medical intervention.

<sup>32</sup> Most people most of the time inhabit differing realities. One theorist on communication, Bion, says that it would be better if people all spoke a different language. Then at least they would know they were not understanding one another. As it is, because we speak a common language, we live with the illusion that we do understand one another. (Bion, 1994, p. 38)

danger to one's own life or another's life is at stake. Pastoral support may be all that is available to them. In considering pastoral assessment for care, listening for the human needs that have gone unmet is another way of drawing on this frame for the role of chaplain or pastor.

This continuum is helpful for one in the role of chaplain or pastor in the ways described. Yet also it must be qualified in the sense that it still is derived from a medical model vantage point that sees one in terms of where she or he lives on the continuum toward the side of illness. Because mental illness is a chronic disease, persons suffering from mental illness often are labeled by way of their disease, and metaphors of such illness are thrust upon them even as military metaphors (battling/war/etc.) are thrust upon persons with cancer. (Sontag, 1983) Seeing persons in the light first of their humanity and not their diagnoses or symptoms is an important reminder for one in the role of chaplain, even with the use of this continuum.

### **Another Metaphorical Frame for Mental Illness – Fever**

A second frame for understanding mental illness from a pastoral perspective is to see it as a metaphorical fever. (J. Angevine, personal communication, Sept. 28, 1997) In the body, the fever, although viewed as harmful, serves a purpose; it is the body's attempt at a cure. When bacteria invade the body, the body responds by spiking a fever as an attempt to create an environment in which the invading bacteria are unable to survive. Even though potentially destructive, the intent of the fever is survival and health.

This same dynamic is true for the symptoms of mental illness. Without some of the symptoms, puzzling and painful and apparently self destructive as they are, persons who have mental illness could well be ignored, sold short, and never receive that which makes for life. The symptoms of mental illness are an attempt at not being overlooked or invisible when viewed from the perspective of pastoral psychology. Perhaps this is a simplistic metaphor. Assuredly

the reality is that a relationship with someone who has a mental illness is filled with confusing dynamics. But if a chaplain (or pastor) is struggling with a given behavior by a person with mental illness, this metaphor can help create a frame for viewing the actions and symptoms by that person, often challenging and difficult, with compassion and care.

Usually the focus of the medical model, as already noted, is to remove symptoms. Yet in this model, the underlying cause and cost of the illness is ignored and possibly lost in all but its physiological manifestation. Persons with mental illness may well be underestimated in terms of what they might have to offer and what they are able to receive as human beings. This is the point at which Pastoral Psychology can offer a different approach. The challenge comes in light of the reality that, for many clergy, offering ministry to persons with a mental illness can seem harder than other ministries simply because they are overwhelmed by the sheer numbers of stereotypes they are required to modify. Especially for churches whose doctrinal systems are based on behavior, the need to set aside moral or ethical norms and judgments and agendas to be present to persons is difficult.

L was a woman diagnosed at different times with bi-polar affective disorder and borderline personality disorder. She also suffered from addiction to alcohol and was in and out of hospitals and treatment centers. After three marriages failed, she returned at age 50 to the parents and hometown she had previously eschewed as one symptom of her illness. Initially her parents were open to helping her, glad for her return and acknowledgement. She was offered a job working in the family business and set up in an apartment. But when her parents learned that a man from her AA group occasionally spent the night at her home, they were concerned for how the town would view her, and therefore them also. They were highly judgmental of her behavior and the job offer was withdrawn and help was taken away. She struggled against recurring

desires to end her life and ended up back in the hospital. Clearly in a pastoral role, withholding judgment from this woman would be important. (Also withholding judgment from her parents would be important if any help was to come to this situation). But this is one example of how the very symptoms of the disease, in this case, casual affairs that mask deep need and pain, can distance others even as it is a cry for help.<sup>33</sup>

This story demonstrates one of the challenges addressed by this metaphorical frame; the ethical assumption that many chaplains or pastors hold regarding behavior. I will discuss this issue of morality further in the theology section in Chapter Five. Here it is important to invite pastors to set aside learned ethical assumptions in order to be able to view the symptoms from a pastoral frame, for the cry of help that they are, and not to stand in judgment.

### **A Third Metaphorical Frame – The Johari Window**

Another frame from the perspective of pastoral psychology that is helpful for the understanding of mental illness is that of the Johari Window. (J. Luft, H. Ingham, 1955) Two doctors named the window after their first names, Joe and Harry. They came up with a simple way of referencing different views and perspectives through the use of a square divided by a cross thus creating four panes resembling a window. In our case, the window represents a person with mental illness. The left side contains the perspective of the person her or himself and

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<sup>33</sup> Certainly in any consideration of behavior, it is important to assess what would be an ethical norm for a person. In this case, for instance, it would be important to assess L's normative way of relationship, to notice if casual affairs were something that were not challenged by her own ethical or religious understanding. Knowing that she came from a conservative religious background that she still embraced by way of theology would help to clarify the symptomatic nature of her sexual encounters.

represents the things about which a person is self-aware, including history, known people, ways of understanding, inner thoughts, hopes, dreams, problems, etc. The top of the window represents the perspective of others with whom the person might be in relationship, everything about this person that can be seen and known or has been told to another person or persons. (See pictured below.)

	Self Knows	Self Doesn't Know
Others know	<i>Pane A</i> Common Knowledge	<i>Pane C</i> Blind Spots
Others don't know	<i>Pane B</i> Secrets	<i>Pane D</i> Soul/Shadow Unconscious

This window provides a strong conceptual understanding of those with mental illness and the effects mental illness wreaks on the human person. Although in the picture above it is balanced, as it represents a person, the size of the different panes may vary greatly.

Mental Illness usually creates a situation in which Pane A, representing common knowledge, is quite small. The reason for this is that one of the main symptoms of mental illness is poor self-insight. So from the perspective of the self, along the left side, little is known by way of self-insight or self-awareness. Besides any memories a person may have, the ability to

make meaning of experience that allows for self-awareness unto identity is often almost non-existent. So many persons suffering from mental illness have little or no sense of their own identity, and therefore lack any authority for their own ways of thinking or for their feelings. Little exists within them that can be in any way self-validating.

The top line of Pane A depicts the norm of the lack of community those with mental illness experience. Often this lack of community contributes to chronic mental illness through unsupportive (at best) or violently hostile (at worst) family systems. Also, given the lack of self-insight, and so identity, little community can be formed outside of the family. The pastoral perspective operates from the premise that mental illness derives from and then contributes to the lack of visibility; few, if any, see the person for who she or he is; know who this person is in her or his heart of hearts.<sup>34</sup>

Pane B stands for those things this particular self is able to know about him or herself and yet keeps from others. These are the secrets held by the self, represented by this windowpane. In considering the meaning of Pane B from a pastoral perspective, two different kinds of secrets exist. The first are secrets that are a part of the wondrous and mysterious person we are. They are a part of the private lives we each get to have, things that we can hold to ourselves or within a freely chosen community of people. The self certainly has the human right and dignity to choose

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<sup>34</sup> That invisibility is both cause and result of mental illness is an operational premise. It is not a truth claim and does not contradict or compete with medical diagnose. The chaplain's pastoral model cannot replace but can live side by side with the physician's medical model. Not that I'm averse to making truth claims. I make this one as strongly as I can: patients at psychiatric hospitals need regular contact with caregivers who operate from a narrative-based pastoral model.

certain boundaries for the information they may offer a given other. Some secrets represent a part of a person's most cherished sense of identity.

The second kind of secret is the secret that can keep one sick; the shaming things that one keeps hidden, fearing either embarrassment or retribution. One example of this second kind of secret would be a secret of abuse that someone holds for fear of shame and/or under threat of great punishment by the abuser. While it would be important not to inform people indiscriminately, bringing this secret into the common knowledge box through telling a caring and knowledgeable other can contribute to healing. Another example would be the various experiences had by the soldiers coming home from Iraq. They need community, persons to tell their stories to who can validate the horror represented by the stories in a way that is healing.<sup>35</sup>

Sometimes a person initially will live in shame, holding what they understand to be that second kind of secret, one that keeps us sick. Then they find a safe enough person and are able to process the secret in such a way that it moves to the common knowledge box in a more general way, or it becomes that first kind of secret, a matter of personal choice and privacy. An example of this would be a gay person who, initially closeted, eventually came out to an inclusive other.

The power of secrets as represented by Pane B invites strong consideration for how the chaplain might approach a patient with mental illness. It is important not to shine a bright light

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<sup>35</sup> These soldiers often receive punitive treatment or a mar on their record if they ask for psychological treatment. But they can have access to the chaplain without the same assumption of ridicule and even sometimes career-destroying weakness. The need for chaplains and pastors to be able to help with assessment and healing from this area of secrets is clear in this context.

onto places of shame before a person has developed the interior skills to process a given experience and the surrounding shame.

Pane C represents our “blind spots” – those things that the self is not able (or chooses not) to see or recognize in her or himself, but which others do see. It is a good guess that anyone reading this right now knows of blind spots in her or his own life that another has shed light on. It can be a frightening or a heady experience to come into material about ourselves that we have previously not been able or willing to see. This is one area in which the mantra, “the mentally ill are just like us only more so” is especially true. All of us have areas that we would prefer not to know about ourselves. When another tries to tell us of this material, often we feel defensive.

K was a CPE intern who was deeply disturbed when one of her peers suggested that she had a judgmental streak. This student couldn't stand hearing such information from the perspective of another. But as she continued to live in her deep hurt, she realized it was the pain of the judgment she saw in her parents that motivated her strong resistance. She didn't want to think she was like them in that regard. Once she was able to own this, she could see that she did struggle with being judgmental, both toward others and toward herself. Her blind spot moved into Common Knowledge and she was able to have compassion, both for herself in the judgment she struggled with, and for her parents, for the weight of judgment that lived in them. Her pain in being shown that blind spot eventually moved her toward healing. This was a student and not a patient. If the blind spot is difficult for someone who is relatively intact emotionally and psychologically, it can be overwhelming for someone who has a fragile psyche. The role of chaplain is not to reveal blind spots for patients, but to offer a safe container as they wrestle with any growing self insight that might emerge.

Pane D, the final square, is that to which neither the self nor others have much direct access. It represents several parts of a person; the soul, the unconscious, the shadow. It holds immense potential and immense limitation. It is a realm of the spiritual, a place from which much of our meaning is made in life and in which meaning is held until it is able to find its way into our awareness. It is also a place that houses the pain we cannot endure or the beauty we cannot behold in ourselves. Much of the theory in Chapters Four and Five offers ways for gentle presence as another connects to that which is represented by Pane D.

These three central metaphorical frames for understanding mental illness, the continuum of mental health, the metaphorical fever and the Johari Window, offer glimpses into ways to view Mental Illness from a pastoral perspective. These glimpses provide powerful ways for the chaplain to have ears to hear the spiritual issues and content for what they are apart from a medical model.

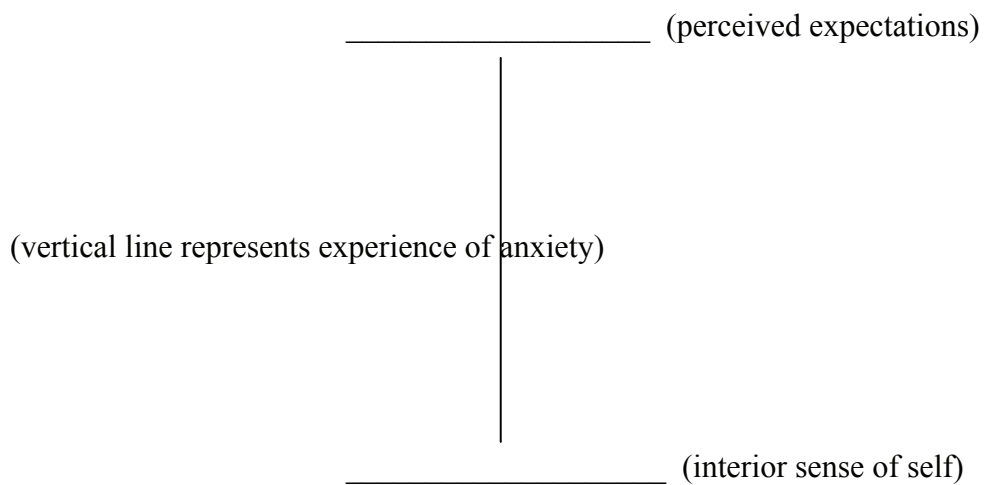
### **Description of Persons with Mental Illness from a Pastoral Perspective**

The pastoral model is attuned to certain traits of persons with mental illness – traits not captured with a physiological description. The following are central operating premises for chaplains working out of the theory offered in the next chapter.

First, those with mental illness are dreadfully hurt. This deep hurt often comes from carrying a sense of failure in the important relationships in their lives. The theory in Chapter Four will point to relationships as central to any sense of the spiritual in life. Those who have not experienced meaningful relationships, who have rather experienced abuse or neglect or both, have therefore not received that which makes for life. Because their context is not one that offers or helps them learn care or trust, nor allows for intimacy, they are relationally impoverished. For this reason, an intentional, authentic and congruent (that is between internal awareness and

external actions) offer of relationship from a chaplain can have powerful and almost immediate effects.

Second, persons suffering from mental illness are extremely anxious. Mental illness is, from a pastoral perspective, a defense against intolerable anxiety. All experience anxiety. To be human is to be anxious. Those with mental illness, however, experience expectations as standards up to which they can never live. The gap between what they sense is expected of them and their interior sense of themselves and their abilities is huge. The distance of that gap is one indicator of the intensity of anxiety felt by the person, as indicated in this diagram.



Third, those with mental illness struggle with identity. They experience little or no self-respect or self-esteem or sense of self. It is difficult enough for any of us to mature into a unique and sufficient self with an intact identity, given the various conflicting messages, family dynamics and cultural confusion surrounding us from the time we become aware. Yet for persons struggling with mental illness in addition to the challenge for identity in general, given the usual lack of support, this task is almost impossible and the lack of any interior sense of identity creates feelings of isolation and loneliness.

Fourth, those with mental illness deal with powerful issues of shame. Shame is connected to and emerges from the struggle with identity. Shame is not about what a person does, but how a person experiences himself. Guilt focuses on behavior, on actions. Shame focuses on being and creates a dynamic in which the self negates the self. They live with the question, “What’s wrong with you?” The same gap between perceived expectations and interior sense of self that produces anxiety also produces shame. With anxiety, the emphasis is on the expectations. With shame, the attention is more on the interior self. Either way, the gap is the primary experience.

Finally, the mentally ill often struggle with an oppressive picture of God. Chapter Four will elaborate on this trait in some depth, but it is important to name in articulating a pastoral model for understanding the experience of those with mental illness in order to offer spiritual care.

The following summarizes these five descriptors.

#### Foci of Pastoral Attention

With patients having a mental illness, seek to notice articulation of the patient’s:

- 1) hurt      2) anxiety      3) identity      4) shame      5) oppressive sense of God

The physiological causes of mental illness need attention. Pharmacology treats the symptoms of the illness. Yet drugs don’t help a person cope with these connected dynamics that cause great suffering. Sometimes with medications people may have less severe experience of some symptoms, but often patients don’t learn how to cope with the traits to which the pastoral model is attuned. The Match Study referenced at the end of Chapter One, along with attesting to relationship as the single most important factor in improvement, also clarified that pharmacological intervention, while it may help symptoms, does not help a person cope with the

dynamics that accompany their illness. The pastoral model of spiritual care and the pastoral relationship that will be invited by the theory in Chapter Four, especially in the context of the state institution, addresses the frames and dynamics named above. The last section of this chapter will offer an understanding of spirituality and religion that can support ministry with those suffering from mental illness.

## **A Look at Religion and Spirituality**

What is religion? What is spirituality? How are these two areas connected and can they be separated? Through the ages these questions have provoked much ink to be spilt and many persons to be burned as heretics. Doctrine and Dogma have been set up in some contexts to insist on the separation of the two. The following is my attempt to offer one understanding of the differentiation and the connection between the two that I believe will be helpful for one who is in the role of chaplain working with people suffering from mental illness. This understanding contributes to a methodology that allows for integrating a host of resources from both the religious and spiritual realms of experience. Chapter Four begins with a theory of spirituality apart from any specific religious or metaphysical understanding. So I will offer a brief description of spirituality here only in order to clarify how I see it as connected to and as standing apart from religion. Then I will consider how religion may and may not be helpful to the perspective of spirituality that is described.

### **Spirituality**

Gerald May offers one helpful way to consider spirituality. He says that the soul is the central essence of a human being. (May, 1987) It is the soul that gives uniqueness and depth to a person; it is the deepest expression of personality and the seat of meaning. The soul can become depleted of energy, either suddenly through an intense life crisis, or in a slower and more

consistent manner through the day-to-day chipping away of difficult life experience. Parker Palmer describes the intense shyness of the soul, this deepest and truest essence of a person. (Palmer, 2004, p. 34) Ann Ulanov also speaks of the soul, that it is a part of the human make up distinct from the psyche or unconscious. (Ulanov, Picturing God, p. 31) All of these voices point to this unique expression of humanity as being in need of tending and care.

In the face of such depletion as described in the previous paragraph, May then offers an image of the human spirit as the re-energizing force for the soul. While the soul alludes to the depths of what it is to be human, the spirit could be described as the height of human experience. The human spirit is actively seeking that which will re-energize, will offer nurture and sustenance to the soul, seeking experience where passion is engaged, seeking to connect to Sources of Energy for this purpose. “Spirituality” is this process of connection.

This distinction between spirit and soul has helpfully informed the pastoral model as employed by some chaplains. Other chaplains will understand the terms differently. Whatever the differences, the pastoral chaplain will be focused on the uniqueness of each patient and the enduring patterns of thought and action in the midst of life’s struggles and changes.

## **Religion**

The word ‘religion’ comes from the Greek word, ‘*ligare*’ which means to connect, to tie, to bind together. The prefix ‘*re*’ indicates doing again or that which can re-tie, or re-bind, can re-connect again and again. In this meaning of the word, religion offers space and form; a container for spirituality. In its different manifestations, the specific container called religion tends to include: a shared framework for teachings about the Ultimate; a moral code or process; an understanding of service; a community of faith; and forms for expression of worship including ritual and liturgy.

This final element of liturgy is a central part of religion, the flow of worship. Liturgy itself comes from two words - the beginning of the word derived from laos, meaning people, and the latter part derived from the same etiology from which we get such words as ergonomics, etc. It means work. Liturgy is the work of the people to be about participating in reconnection. Religion is a powerful offering and gift as it helps persons reconnect with their experience of the Ultimate, nurtures their spiritual health by embracing meaning in life. In this way, religion serves as a container for spirituality.

Many central contexts of need for this nurture and re-energizing through religion exist. One is in the face of the day-to-day chipping away of spirit. Another is through providing the potential for deepening of meaning, offering a perspective to see the extraordinary in the midst of the ordinariness of life. And one other is in the face of tragedy or crisis. Concerning the latter context, when a sudden death or loss in a family affects an entire community of faith, coming together for worship can provide powerful and supportive processes for the spiritual task of integrating deep grief and other painful feelings connected to loss. Religion has the potential to offer strong pastoral containers to aid those involved in church or synagogue or mosque in learning how to integrate loss and other experiences in a profound way for soul-sustaining meaning within the context of an ongoing community of care.

In the realm of service, the religious community, by virtue of sheer numbers of people can generate resources from a vision of ministry that points them toward addressing some larger need. Additionally, countless persons have found meaning and identity through participation in a cause of social justice or concern. In such places, the pastoral meets the prophetic allowing a person to spend meaningful time and energy in re-energizing ministry.

So, at its best, religion is responsive to many needs. It offers connection to a Source of Energy and helps to stand with losses great and small. Religion nurtures and revitalizes the human spirit. Also at its best religion is open to piece together many different pictures of God that point to an Ineffable Reality. (Ulanov, 2001, p. 20) Anyone reading through the many sources depicting human history and learning will glimpse traces of that reality running through the various disciplines of science, music, math, literature, works of art, depth psychology as well as theology. Through each of these disciplines, lives a possibility of revitalizing the human spirit. Finally, at its best religion aids a process of spirituality that creates a life worth living; that allows another to feel alive, to have a sense of belonging, to experience aliveness in relationships. Life feels worthwhile and directed by meaning and yields moments of joy, ecstasy, gratitude, connection, all of the words that could be used to describe the theological word, heaven (or salvation). (Ulanov, 2001, p. 9)

### **What Happens to Take Away this Spiritual Focus for Religion?**

What has been described as religion thus far has been the offering of a container that allows the unique and individual soul a safe enough space to receive nurture and energy for sustaining a life worth living. However, another side to religion exists, in the Christian Church and throughout the institution of religion in this world. At the largest scale, religious wars and persecutions seek to defeat other traditions' pictures of the Ultimate and impose their own. (Ulanov, 2001, p.) And bringing this less positive side of religion to a more individual level, rather than offering a reenergizing container for spirituality, religion can bind and hold in bondage, can become a guilt-dealing experience, can be that which drains energy and resources. This is the experience of many with mental illness. Their struggles and their stories reveal deeply beleaguered psyches and souls, living in fear and guilt stimulated by oppressive religious

experience, and with no sense of connection to their essence within, to a life-sustaining, soul-sustaining faith.

I don't want to utterly separate religious experience from the institution of religion. One can be in a more oppressive institutional expression of religion, and yet embrace a style of worship that energizes the spirit. However, religion becomes unhelpful as a container for spirituality when it moves away from a focus on nurture and care for the essence of soul as its central task, and moves toward a defensive stance of maintaining an external system of beliefs or doctrine, insisting on adherence to those beliefs. Rather than something central to life and integrated into all of life, religion becomes a set of particular beliefs running parallel to the rest of a person's life, beliefs and doctrines and rules that often have little connection to a soul level of need. When this happens, the experience of religion becomes little more than a thin religious veneer with gate rules of behavior and limited pastoral or sacramental ministries or social programs. This dynamic of contrast has been noticed in a variety of contexts.

### **Examples of Contrast Between Identity-Based Faith and Belief-Based Identity**

Anne Graber, a teacher of Frankl's Logotherapy, described this dynamic through an illustration of an experience she had at a worldwide conference on religion. (Graber, 2005) Graber noted that, on the one hand, those for whom beliefs flowed from their center and were connected to their sense of identity, standing alongside and relating to persons of differing beliefs posed no threat. For these folks, connection to an underlying foundation of faith was not threatened by diversity. On the other hand, people whose identity derived from imposed beliefs, rather than their beliefs emerging from their sense of identity, were unable to connect with others and lived in a defensive posture. In Graber's example, those with faith grounded in identity were

strongly connected, while those with identity grounded in belief disengaged from the rest, and spent the time arguing amongst themselves about specific right beliefs.<sup>36</sup>

An example from Hebrew Scripture also illustrates the distinction between faith flowing from identity and identity flowing from external authority. The prophet Isaiah sees a huge opportunity in the wake of the exile. He invites the Israelites living in different areas to see themselves as beacons of faith, to shine the light of faith wherever they find themselves, that people will see the powerful and rich possibility of a life lived from a depth of faith in the face of all of life's challenges. ("It is too light a thing that you should be my servant to raise up the tribes of Jacob and to restore the survivors of Israel; I will give you as a light to the nations...") (NRSV, Isa. 49:6) Their faith lies on a foundation of an identity as a light to the nations.

But Ezra says that purity of culture is the only way for Israel to continue to exist "You have trespassed and married foreign women," he says, and he demands an ethnic cleansing: "We have broken faith with our God and have married foreign women...but even now there is hope... Let us make a covenant with our God to send away all these wives and their children... Ezra..."

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<sup>36</sup> An experience of my own that supported this description of Graber's, of this convergence of the spiritual between very different religious expressions, happened for me in an educational context when I found myself partnered with a Moslem Imam. Our task was to describe something that added meaning to life on a spiritual level. We both told experiences of losing our mothers. And in our continued sharing, we found that both of us had a sense of the presence of spirit from our mother's because of the same symbolic experience. Although both of us were supported by very different religious containers that were meaningful to each of us, we were deeply fed by one another at the soul level, at the point of essence, without ever bringing in any religious language or understanding.

made... all Israel swear that they would do as had been said.” (NRSV, Ezra 10:2-3,5) Ezra believed the only way the Jewish nation would survive was to call everyone home, to insist that they give up their foreign wives and ways and by way of repentance, adhere every more strongly to a rigorous legal system. Otherwise, he saw no way for them to maintain an identity as God’s people. Their identity derives from a rigorously imposed external system of belief and behavior.

### **Religious Beliefs and Soul Needs**

A threat to identity and meaning (and power) is a central reason for this other picture of religion, in which persons are exhorted to do or to behave in certain ways, often under threat of exclusion. I don’t mean to imply judgment in making such descriptions of systems of religion. In the face of externally imposed beliefs, any threat to these beliefs is experienced as a threat to identity and meaning, to the felt need for power in the face of the changes and chances of life. Any challenge to beliefs can feel like a threat to one’s very existence. When beliefs come from without and not from a connection to one’s center, to a strong sense of identity, the opportunity to integrate life experience in order to deepen and mature identity (and therefore spirituality) does not exist. Seldom is personal participation, much less integration modeled or encouraged. Even some of the expressions of the Christian Religion not so laced with an oppressive agenda struggle to be about a way of creating a religious container that can touch at depth into life questions and soul-level needs.

The next chapter will look at theory to support the chaplain role. How might we understand human spirituality in more depth? How might we facilitate re-energizing, sustaining and nurturing the spirit apart from religion or specific religious practices? Then how might the chaplain be supported by theory to discern and utilize powerful religious expressions for spiritual connections as they encounter them in patients? Finally, in the wake of this theory, what

theology can provide a foundation for a chaplain serving those with mental illness? How are chaplains formed to offer this service? These are the questions I intend to address.

In brief, then, along with this pastoral model of understanding those with mental illness, and this understanding of religion as connected to and different from spirituality, the methodology used in this entire work involves an academic approach that utilizes anecdote/narrative and describes a process of reflection on experience. These non-quantitative methods are central to the integration and practice of the role of chaplain. They are true to the theory I am inviting, as well as the theology and formation processes concluded from this theory. It is imperative, in order to maintain integrity, that theory be offered by way of description and narrative. Through a methodology of description and narrative, the theory offered can provide a witness to and an offering of an experienced means for ministry with those who suffer from mental illness and who find themselves in institutions of care.

## **Chapter Four**

### **A Cornerstone of Support: Theory and Theology of Care**

#### **Introduction**

#### **Spirituality and the Role of Chaplain**

“We don’t need a chaplain here. No one is dying.”

“Why are you here? This patient’s religious language is delusional.”

“We don’t need a chaplain, the doctor is here.”

Statements such as these, often spoken by medical staff, indicate a strong need to clarify the role of chaplain and the function of a pastoral model of spiritual care that is more than performing specifically religious rituals. The chaplain’s task of caring for soul and spirit does not require ostensibly religious or spiritual language to address things of great spiritual import for persons.

If we consider all that makes up the human person: a rational, mental and intellectual self, a physical self, an emotional self, a social, sexual, and spiritual self, we can readily see that these cannot be compartmentalized. All that we are as human beings is affected by and affects our human spirituality. (Baker, 1995). Listening for inner wisdom in any of these areas has strong implications for the renewal of spirit and the life of the soul. The first part of Chapter Four hones in on theory to support the chaplain in making assessments and offering care from the realm of human spirituality, or to use Victor Frankl’s term, the noetic (see glossary), apart from specific religious beliefs or disciplines or images.

#### **The First of Three Components of Human Spirituality – The Self**

The first component of the noetic is the unique person. This component contains all that makes up that person including: her or his story, experiences, hopes, dreams, fears, hurts,

disappointments, the body and mind, all that is contained in the soul and potentially energizing to the spirit, the deepest sense of identity in one's heart of hearts. This self embraces the depth of potential wisdom within each person. It speaks to the coalescence of all that gives a person enough of a sense of self to live well in the world. Mental illness affects all aspects of a person, including this first component of the noetic, the self.

A brief story by Soren Kirkegarrrd demonstrates how mental illness can challenge the self, the sense of identity. Although the character in this story suffers from alcoholism, he might as well have had any mental illness that precludes a coherent sense of identity. The story goes thusly: a man suffering from the mental illness of addiction came barefoot to a town and earned some money which he spent on new socks and shoes and then had enough left over to get himself drunk. Walking along a road toward home, he passed out. He was awakened the next day by a cart driving by. The driver told him to move lest his legs be run over. The drunk saw the unfamiliar and expensive new socks and shoes on his feet and invited the driver to "Go ahead, they aren't my legs". (Kierkegaard, 1941)

This brief and darkly amusing story reveals the profound lack of insight into one's self and subsequent loss of identity characteristic of the mentally ill, which points to a painful loss of noetic potential. Because of the inability to discern that which can satisfy soul and spirit, can help with coalescing identity, persons with mental illness may have no choice of action or activity other than to seek distraction in a given moment. The medical and scientific tests that prove the loss of quantity of life for mentally ill persons do not consider the issue of quality of life that is of central concern to the role of chaplain.

Trained chaplains can make pastoral assessments of lack of noetic awareness, the lack of insight, identity and personality. In light of this assessment, the chaplain role can bring a caring

and attentive presence trained to hear and mirror noetic potential in conversation. Such a chaplain can provide the depth of listening presence for coherence of the disintegrated parts of the personality or identity to gel, even if for a few moments.

This assessment is especially difficult for those suffering with addiction because addictive substances compromise the physiological processes requisite for self-consciousness. The result is that an addict lives with a psychological makeup of hiddenness. Still, the role of the chaplain can provide a safe enough container and caring enough confrontation that allows for visibility, however briefly, even in the long-term addict.

In a recent spirituality group for persons suffering from addiction, a chaplain, using a poem of Rilke, “God speaks to each of us as he makes us,” offered this kind of space and process. Many of those present became highly reflective. One man recognized that he had depended all of his life on external expectations for any sense of identity. Through his processing of poetry, he glimpsed an alternative; a possibility of finding self and identity within. This patient has more interior reflection to do, but the reflective process of this discovery nurtured his noetic self.

In regards to this first component of spirituality, it is crucial for the chaplain to assess the noetic sense of identity and congruent meaning that is or is not a part of the make-up of this person.

### **The Second of the Three Components of Spirituality: The Other**

The second component has to do with relationships between self and other. The other includes other individual persons as well as Reality taken as a whole. Through relationship with the “other/Other” the self receives visibility and validation from an external source. When a self can become grounded in a non-controlling other in this way, a personal identity and positive self

and potential is created. With this kind of validating and mirroring of experience and reality, a person is able to live with potential and possibility and a sense of purpose such that the person is able to connect to the noetic for meaning. The chaplain or pastor can provide powerful presence through such qualities as acceptance, compassion, understanding and validation that can help another find and attend to the wisdom that lives within.<sup>37</sup> A person is empowered to experience connection beyond her or his own isolated (and unconscious) presence in the world.

S suffered from Alzheimer's. Her dementia was getting more pronounced. One night in the hospital she returned again and again to the water fountain appearing to be in some distress. Finally a chaplain was called who asked what the water was offering to her. She said that it was communion. With a little more gentle conversation, the chaplain was able to hear S's need for connection with God, and an underlying fear that if she were to forget God, maybe God would forget her. The chaplain said, "If your disease ever takes you to a point where you do forget God, God will never forget you." This chaplain thus gave voice to a crucial aspect of S's own religious/spiritual understanding. In doing so, the chaplain allowed S to glimpse her own resources for insight and assurance. S's distress shifted to an expression of relief as she connected with the chaplain and as her depth of concern about being forgotten was made clearly visible to herself.

Part of the reason that pastoral presence is so important in attending to the first component of self is that no one can connect with her or his interior without intentional community from the other. While Frankl insists that meaning is central for the noetic, others

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<sup>37</sup> The effect may be momentary – as indeed is life. Sometimes a pastoral, accepting presence begins a long path to healing and wholeness. Other times the brief moment of compassion is all and must be held sufficient in and of itself.

have recognized that for meaning to happen, relationship with the other in community is necessary as well. Gilligan and other women seeking collegiality in the midst of a patriarchal academia brought a new awareness to psychology through the experience of their need for community. In their experience and later their statistical findings, community must accompany any process of meaning making for an effective and integrated outcome of meaning. (Gilligan, 1992)

The need for the other/Other is a physiological reality contained in the human limbic system. Physiologically, research indicates that the limbic system is the seat, not only of the emotional, but also of the noetic, or spirituality for the individual. This system is required in order to relate well to others and to connect to any sense of the noetic. This limbic system needs resonance or feedback in order for a person to coalesce into a sense of her or himself. The system is designed to connect in order to survive. The more links that are formed by relationship, the more possibility for reflection. (Clayton, 2007). Without such links, a person has hosts of emotions and no way to reflect on them or to touch into the essence of identity and reality within, which is a description of many of the symptoms of those with mental illness. The second component of spirituality (the other) then becomes a necessity in some form in order for the first (the self) to develop.

A dramatic example showing what happens without such connections was found in a study by German Emperor Frederick II (1194-1250). He wanted to prove the assumption that Latin was the primordial language people were born to speak. The assumption was to be proven by taking a group of newborn babies and keeping them in a nursery in which nurses would care for all physical needs of feeding and changing, but would offer no other communication in any

other way, including touch or facial expression. The sad result of this study was that all the children died within six months. (Frederick II, 2007)

Although this level of absolute neglect is rare, relational deprivation through neglect results physiologically in fewer dopamine transmitters that are responsible for positive feelings. This is the situation for many children on the Children's Psychiatric Unit in the state hospital. Severe neglect has caused them great suffering and many have little experience with relationships that nurture life and meaning. In the face of no 'other' to stimulate the limbic system, noetic blocks are woven in as part of the fabric of being, creating a void of identity. The self is unable to develop the sense of identity that makes for a purposeful life.<sup>38</sup>

### **The Third Component – The Space Between**

This brings us to the third component of spirituality. The first was the person her or himself. The second was the necessary other. And the third is the space in-between. This space is the space of potential and possibility for a person. Winnecott spoke of it as the space for play, a space that gives the possibility of lively and life-giving experience and meaning. (Winnicott, 1971, ch.1) For children, such play space between the self and other is essential. For adults, their own meaningful play lives in that space between to create a meaningful and positive life. When this space between turns into isolating distance without meaning or noetic experience, the chaplain role has the potential to help isolation transition once again into creative space.

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<sup>38</sup> The medical model produces research that tells us about the workings of limbic systems and dopamine transmitters. It yields data on the role of relationships in brain development. While this information provides a helpful theoretical backdrop for the chaplain's work, the medical model alone cannot, as the pastoral model does, tell us how to do spiritual care – how, that is, to bring presence and help find meaning in narrative to offer effective patient care.

These, then, are the three main components of the noetic, of the human being as a spiritual person. The role of chaplain, from the perspective of a pastoral model, can make an assessment of this noetic state of being contained in a person's narrative. Pastorally effective chaplains will have seriously engaged a spiritual path and undergone processes variously called "being formed at the level of their own being," or "intentionally integrating their own primordial wounds and true selves." These chaplains will have integrated theory of personality and human behavior and will be able to stand on the foundation of their own theological understanding while open and aware of depths of theological and religious possibility in many faith traditions. Such chaplains can present a congruent and authentic presence to someone in this painful place of being. They can hear noetic blocks and can offer educated validation and acceptance by way of absolute positive regard, as well as other means of in-depth and skilled listening. These are rare and powerful offerings in light of such noetic needs. They are desperately needed offerings given the level of deprivation that is often the experience of those with mental illness. While these interventions may appear simple, the enacting of them by a chaplain is not simple. Yet they hold profound possibility for a patient as they emerge from a well-trained ear listening for the depths of potential noetic meaning.

### **The Need for a Map to Navigate the Space Between**

Pastoral training occurs primarily in seminaries and divinity schools. Yet these institutions focus on academic training, formation in theology, and knowledge of scriptures. The theoretical basis and personal integrative work that fosters the level of presence provided by effective chaplains is seldom included nor valued in the seminary curriculum. (The value of CPE as a reflective integrative process in a seminary curriculum is seen more by judicatories or by some more practically minded seminary professors.) The rest of this section of Chapter Four

offers a metaphorical map, containing some routes, some integrative spiritual themes to help with understanding, assessing and offering care from the perspective of that third component of human spirituality of the space between. For persons with mental illness, who often have neither much knowledge of the self nor much knowledge of (or support from) the other, that space between becomes isolating separation.

### **Space Becomes Gap**

People increasingly experience dis-integration. Rather than connection to self and other and an experience of the creative space between, those suffering from mental illness experience isolation, a sense of living removed from others and the world. From a pastoral perspective, the patients I see in my context of ministry have come to represent for me exaggerated mirrors of our human condition. They have sensitivity to life that reflects the mainstream of human experience, but without the ability that most of us have to hide symptoms and struggles. These patients do not live well in the world as it is and struggle at the best of times to have an integrated sense of self and personality.

In addition to the patients served in this hospital, a host of folks training for ministry move through my office who are young, older, with or without strong financial resources, who struggle with issues of identity and community and live with a sense of existential dread that they seek to hide, even from themselves. I know this as I have the same experiences living within myself. Some with the most well-developed egos and personalities struggle with how to live well in these days of war and terror (and the assumption that war has any hope of dealing with terror), this era in which a fragile environment is challenged by a culture of rampant consumption, this age in which freedom is given away in the illusory hope of security and in which the lion's share of public and private investment funds development of ever more

technologies of war and pollution and resource-depletion rather than technologies facilitating community, conservation, and environmental protection.

In the sixties and seventies, this existential crisis came to awareness in a way that shook up US culture. Drugs offered an escape from that immediate encounter with the existential reality. Today, in addition to the continuing drug crisis, ubiquitous video screens (of computers, television, movies) disguise the existential crisis of our souls.

Ann Ulanov's work develops the image of a "gap" that has increasingly come to replace "space." While "space" affords the distance and distinction necessary for identity and for creative connection both to self and other, "gap" occurs when the distance becomes too great for connection and thus too great for identity formation that depends on connection. (Ulanov, 2001, p. 140) Because the imperative of the mainstream of culture, including parents, teachers, employers, is to pay attention 'out here', to externals, the inner self feels (and is) abandoned. Gap is experienced in a variety of ways. The unique unknown self is a mystery. Further, that lack of connection or insight with the interior, and the absence of a sense of self to bring to relationship renders a person unable to experience a connection to others or to "Reality-as-a-whole" as seen through such linguistic-theological lenses as God or the unknowable Divine or the Ultimate Mystery. Rather than a space between that allows for personal identity to form through inner connection and supportive community, that creative space fractures, becomes a gap. The gap isolates from within and without.

Other images augment the understanding that the gap image gives. In a letter to Bill W, the founder of AA, Carl Jung named the struggle of addiction as the struggle of *Spiritus contra spiritum*, meaning, "the Spirit" (i.e. the sense of connection with the noetic) against the spirits (in this case of alcohol). (Wilson, Jung, 1987) This image of Spirit against spirits is one way to

develop or flesh out the image of space becoming gap. The “spirits” block or disconnect the person from the noetic. They cut off the person from the sense of aliveness that makes for a life worth living. They create gap.

Other metaphors also cohere with the images of gap/space, of the psyche/soul relationship. Victor Frankl has pictured a system of the way in which the physical, the psychological (containing the intellect and emotions) and the spiritual parts of a human being work in relationship. (Graber, 2004) He uses a funnel metaphor: the spiritual part of a human being is channeled from above the person and flows down. Decades later, Healing Touch, an energy-based, holistic system of healing, posits a similar way of viewing the human person. The Crown Chakra, located at the top of the head, is the receptor for things spiritual, almost exactly as Frankl drew his model. In this understanding, a person receives stimulus from the world as a (often unconscious) noetic experience. This intuitive noetic stimulus is received and processed by the intellect and emotions and takes tangible reality in physical expression. When this receptive funnel, representing the receiving of the constant noetic offerings from the world is blocked, then persons struggle to live well and with a sense of meaning and purpose. To use May’s language, no re-energizing of the spirit or touching into the depths of the noetic needs of the soul is possible. I have seen this to be a common experience of persons with mental illness.

Marsha Linehan, drawing from Hegel’s dialectic has created a theory of treatment for people with Borderline Personality Disorder<sup>39</sup>. Linehan (1993) has pointed to dualism and

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<sup>39</sup> Linehan’s treatment modality called Dialectical Behavior Therapy (DBT) was developed specifically for Borderline patients. But studies have revealed that most persons from Western households live with a lack of validation for feelings and experience that create the sense of what

dualistic thinking as one of the most painful blocks for persons, especially those with mental illness. The either/or thinking that maintains blame, shame and judgment toward self and others is an almost insurmountable block to experiencing a creative space between. Rather folks lose themselves either in a painful and confusing turmoil of emotions, or in an extreme and disconnected form of reason. Either one creates isolation from within and without.

Those with mental illness regularly have the experience of a noetic block, of an inability to connect, of a gap. They are especially vulnerable to this gap or noetic block that prevents addressing noetic needs that provide a sense of quality to life. Grief and loss from the past, and fear that looks to the future and doesn't see what makes for life are all intensified by the experience of mental illness. It is difficult for anyone to process and integrate the deep hurt of loss. When shame and guilt and a host of other realities assaulting the fragile psyche of those with mental illness complicate that loss, the experience of gap, of noetic block, is all the more intensified.

### **The Chaplain in the Gap**

The chaplain's ministry approaches the patient from a pastoral model, and that model is not about solutions or fixing situations or people, but about listening to narrative and attending to experience and meaning of any given patient.<sup>40</sup> The chaplain role therefore has the potential to

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I am calling "gap." So DBT has been found to be effective in creating a greater sense of satisfaction in life for the larger population as well.

<sup>40</sup> To say that the model is not about solutions and fixing is not to say that chaplains cannot be effective. Chaplains can be effective and some are more often effective than others. They are most likely to be effective, however, according to the pastoral model, when they are not focused

bring meaning to the gap experience. The role allows for communication and connection rather than a further isolating response of providing answers or treatment from an exterior agenda, whether medical or theological. Because presence is about relationship more than any specific issue, even a spiritual issue, it can create transitional space in which the noetic block diminishes for a moment. The pastoral presence allows expression of the grief, fear, guilt and regret, and creates space for the emergence of wisdom from the soul level of the person.

Patient M, who had been fairly agitated, was referred to a chaplain intern under my supervision. As the chaplain intern spent time with M, he discerned or assessed that M needed a lot of safe space to tell his story. M spoke and wept about the loss of his son. He then looked directly at the chaplain intern and said, “Thank you for listening to me. You have sat with me and looked right at me and allowed me to tell my story and experience. You are the first person who has done that. That is what I have really needed.” Certainly this chaplain’s presence contributed to the coalescing of this patient’s sense of self enough to leave the hospital.

### **Potential for Gap Becoming Space: Resources for the Chaplain in the Gap**

#### **Frankl’s Resource for Assessment: The Soul’s Need for Meaning**

While Ulanov provides the image of the gap and offers a powerful description of the gap experience, Frankl offers some more specific theory as guide, in discernment of what may be contributing to the experience of gap, and in offering care in the midst of the gap experience. His central focus is making meaning. Meaning is central for the noetic in life; meaning sustains the soul. Frankl suggests three main avenues for meaning in life – to support the space between.

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on effectiveness. News of apparent positive results from a pastoral encounter always comes to the chaplain as nonessential – an unexpected celebration.

These give the chaplain's ears potential help in listening to another's gap experience. (Frankl, 1988)

The first avenue is through what we are able to give to the world, how we are able to express our unique personhood in the world. It is a universal human need to offer something through relationships and through actions performed beyond ourselves, for others, for the world. When this need cannot be realized, a painful noetic block or experience of gap occurs.

K was an elderly person whose life had become limited by illness and other physically devastating experience that compromised his independence and ability to function freely. Confined to institutions and beds, K could no longer contribute in ways that once were natural and sustained meaning and soul. This reality can be even more painful for the elderly, such as K, suffering from mental illness or dementia. It is often the central noetic block creating the painful and dark experience of gap that we call depression.

The second avenue to meaning and purpose, to the noetic in life, is through what we are able to receive from the world. It is a universal human need to receive something through relationship with others or Reality-as-a-whole (e.g. the beauty of creation); through integrating such experience. Certainly the elderly can experience a loss of this second element in the same way they can lose the first element. Even as they no longer can give of themselves, they also lose connection to sustaining community that can give a sense of purpose. Many with mental illness are stuck, are disconnected from others and unable to receive that which makes for life. Sometimes this sense of disconnection is so painful that ending life seems a better alternative. Sometimes it seems to a mentally ill person that the other who is saying that suicide is not preferred is the insane one in the room.

The third avenue of meaning asks how we are able to make meaning in the face of intolerable suffering. This could apply to the first two ways above when nothing can change the situation. When no other options are available, how one might face into the immediate situation and still find meaning. Another piece of theory that can help to frame this third experience of intolerable suffering is the final stage of Erik Erikson's theory (Erikson, 1964). He suggests that the central conflict in older life (i.e. 65 to death) is integrity vs. despair. The challenge standing behind this conflict is to look at one's life as it has been lived and, in the face of potential despair, to embrace a sense of integrity for the decisions, good or bad, that were made in life as it was lived. While Erikson places this life task at the end of life; most any experience that calls for a person to make meaning in the face of intolerable suffering is a task in which a person is seeking to find some sense of meaning for events, some sense of integrity in the face of the despair of loss, grief and/or guilt.

These three avenues of making meaning are helpful to the chaplain in making assessment of people suffering from mental illness. Noting the loss of some way to give to the world, recognizing when the means of receiving from the world are no longer present, and facing into intolerable suffering, all give hints as to where to focus listening. The way in which the chaplain hears and responds to these noetic issues in life is central to the role, especially in the institution where others seldom have the time, even if they have the awareness, to attend to a noetic possibility. For Frankl, the noetic task of life is to hear the noetic questions that the universe or life itself uniquely poses to each of us. The challenge is not so much to ask questions of or about our life as to hear the questions posed to us in the living of life. Listening from this awareness when with a person with mental illness is a highly respectful way of presence and assumes that this person is well able to engage at a spiritual level.

## Object Relations for the Gap

Object Relations (OR) is currently one of the most utilized psychological theories for under girding pastoral care. OR provides handholds for assessment and care, and it ties together family systems thought (which has been used in the church for many years to understand the dynamics that operate in congregations) with psychoanalytic concepts. It also gives a chaplain a tool for self-supervision in the moment, to discern how her or his issues might become connected with the care-receiver's issues.

OR gives perspective, independent of any particular religious understanding, for the consideration of spiritual meaning. It also provides understanding (as it is utilized in the next section) in a religious perspective. A full description of this theory is not my task. What follows is a description of some of the stages and coping strategies that are helpful in noticing noetic needs. (Klein, 1975) In the next section of this chapter, understandings of some of the theoretical premises are considered.

OR theory begins with the central "Object", which is the mother (or more recently, with recognition of the increasing role of fathers in bonding with and raising children, the parent). In order to develop, a child needs what OR calls the "good enough parent" who can provide a "facilitating environment." Already the parallels to the task of pastoral care are evident. Chaplain interns entering a new role for ministry with the mentally ill often worry about the "right" thing to say in a given situation. The "good enough" chaplain or pastor, rather than focusing on "right" words, is invited to offer space through listening and assessing a need for care (i.e. a facilitating environment).

OR theory calls for allowing space for something to emerge, whether that be healing tears, painful anger, deep woundedness, or a mirror for a person to see themselves anew. OR

theory asks that the chaplain self-assess with the question: How much am I able to adjust to the unique person before me, and/or how much does this person have to adjust to elicit my positive or nurturing or caring response?<sup>41</sup> Two dynamics from OR theory help with pastoral assessment. One is called splitting. “Splitting” refers to seeing things as either/or, as all good or all bad. The person who splits becomes stuck in dualistic judgment towards self or other. Noticing this either/or language can point to places of noetic wounds or blocks. The other dynamic is introjection, which refers to taking into oneself certain aspects of personality. If a chaplain finds her or himself responding in an uncharacteristic way, perhaps either the patient or the chaplain has introjected some material.<sup>42</sup>

Another helpful feature of OR theory is the phases of life it describes. The first phase spans the first month of life. In this phase an infant is unaware of the world, has no sense of a self and is completely dependent on the world. Another needs to recognize the messages of pain, pleasure and need this child is unconsciously sending. For the child, the only activities are those natural functions: eating, sleeping, crying, urinating, and defecating. The role of the good

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<sup>41</sup> Edwin Friedman’s work emphasizes “non-anxious presence.” This concept is another way of pointing to creating a facilitating environment. Concern about having the “right” words in situations for which no words exist emerges from a desire to fix or find solutions. Friedman says that, in a difficult pastoral situation, caregivers too often either distance themselves, or stay present but take on anxiety that blocks resources and hinders listening. A chaplain in the grip of anxiety focuses on ostensive solutions found in theological absolutes or clichés, losing the offering of space and adding to the gap. (Friedman, 1985)

<sup>42</sup> This dynamic will be given further attention later in this section when looking at contributions from Pamela Cooper-White.

enough parent is to bring a “good enough” consistent presence in the form of food and changing diapers, attending to temperature, etc.

In the pastoral role, this phase happens in the wake of the most intense loss. For some, a loss can be so great as to make them unaware of the world or of their own needs. Some of those natural activities like eating or sleeping seem impossible. Pastoral assessment that a patient is in this phase of deep crisis invites provision of consistent presence and help with ordinary human needs. To try to move someone from such a place in an early phase of crisis can be harmful. To have any expectations that a person be other than they are in the immediate wake of extreme loss or crisis is to hinder the overall process of that person in dealing with the loss. For a person struggling with a mental illness who finds her or himself in the hospital with no familiar emotional connections and little if any sense of connection with the self, the same response is indicated. Presence from a chaplain to such deep need can be powerful and caring.

The second phase occurs from about four weeks up to six months. In this phase the child begins to show increased sensitivity to the outside world, begins to notice that an object exists that satisfies her needs. When the object does consistently meet the need, the child begins to develop a “confident expectation” and is able to wait without undue panic or anxiety. If that “good enough” parent can offer a holding place for the child, the child will begin to catch the parent’s sense of security and power and will gain a healthy illusion of control. This allows for an initial sense of trust and confidence for the environment.

Again, parallels emerge for the pastoral role and standing in the gap with a person. People with mental illness who come to the hospital have significant feelings and deep spiritual needs connected to those (often unconscious) feelings. If a chaplain offers a listening presence that hears and reflects feelings, that notices the needs living in the words, the patient has a

chance to experience trust and confidence. Through this form of presence, parts of their faith or spirituality or religion that seemed to have lost any life may become resources to them again.

They may receive what they need to get through a difficult time of life.

The third phase happens when a child begins to realize that others exist apart from the child's self, and that the central object of the parent is different from other objects or persons. In this stage, a parent's responses determine what is safe and unsafe. Several theoretical guides emerge from this stage as adapted to the chaplain role.

First, familiarity with OR theory may sensitize a chaplain to notice when a person is leaving a grieving experience of utter dependency and turning a corner to more independence of thought and integration of loss.

Second, OR theory provides the chaplain with the concept of a transitional object. When primary or familiar objects are not available, a transitional object can serve to offer the "other" for a person in the midst of a difficult situation. The chaplain may be such a transitional object for patients with mental illness who come to the hospital in disorientation.<sup>43</sup>

Third, OR theory directs attention to the observation that the parent's response determines what is safe and what is unsafe. Pastors or chaplains may find themselves in the position of parent. Pastors are given a great deal of power for persons from certain religious cultures to say what is safe or appropriate. This dynamic that lives still in some religious traditions has historically and even today caused great suffering. Undue power accorded to clergy produced the inquisitions in the Middle Ages, and produces the soul-oppressing religious "oughts" offered today from control-minded ministers. The pastor who responds with correct

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<sup>43</sup> More will be said in the next part of this chapter on objects and transitional objects.

religious information to a religious question that hides a deep pastoral need is inappropriately using power conferred upon her or him.

Persons looking to a religious tradition with great interior need have had those needs ignored in large and small ways by those responding with external objective answers. The skilled chaplain will refrain from taking or wielding that power. Instead, the chaplain will listen deeply to a question, whether it be from someone trying to decide about removing a family member from life support, or someone wondering what sin they committed to find themselves in a psychiatric hospital, or someone asking for explanation of a scriptural passage. The chaplain will refrain from objective response, will listen for the pastoral concern and need living deep within a person, and will create a space for that person to begin to have a sense of themselves. Such a chaplain redirects projections of authority into the creation of a safe container to foster pastoral and spiritual individuation in a deeply meaningful way.

I will not delve into the other stages described in OR theory. This brief “highlight reel” of OR theory illustrates the theory’s utility for chaplains. It should be noted, however, that the chaplain’s use of this psychological theory is a very different process from the psychologist’s use. The chaplain’s sole concern is in creating a caring relationship, listening for the pastoral or noetic concern and creating the space in which the other can experience visibility and care.

### **Psyche and Soul Relationship: Bolen’s Contribution to Supportive Theory**

Jean Shinoda Bolen, in her practice as a psychologist, works with the dying. In her writing, she refers to Lawrence LeShaun, a colleague who used a Freudian focus in his work with dying patients and then shifted to a different stance. (Bolen, 1996, p. 80ff) The Freudian theory pointed him toward such questions as “What’s wrong with this patient? How did he or she get this way? What can be done about it?” These questions may help with some types of

emotional or cognitive problems, but not for those with cancer, nor for those with chronic mental illness. LeShaun found that patients often gained insights into the issues they lived with, some of the etiology of their actions, and then they died. Inspired by LeShaun, Bolen brought a Jungian focus. This focus listened to the soul, sought to help another listen for the noetic needs, which resulted in persons surviving their cancer. In contrast, the Freudian focus of insight “simply (did) not mobilize the person’s self-healing abilities and bring them to the aid of the medical program.” (Bolen, 1996, p. 81)

Instead of asking what is “wrong” with this person, Bolen initially shifted to follow LeShaun’s stance of seeking what is “right” with this person. Yet it quickly became clear that this, too, retained categories of “right and wrong,” was still dualistic, and could be blaming. So, and this is crucial in working with persons suffering from mental illness or addiction, she began to ask or to listen for, in a myriad of ways, “What is true for this person?” In seeking for that truth, she listened for the noetic needs, especially the ones that may have been covered or set aside due to perceived expectations from family or community surrounding a person. Those with mental illness often cover up their sense of soul and self because of great sensitivity to perceived expectation. Bolen’s stance as a presence listening for what is true in a given person is a powerful and crucial one for the chaplain. It is often difficult and tedious work to listen for this noetic reality with the mentally ill.

One chaplain visited a patient, L, on and off for many years, often growing tired of the litany of delusion that she espoused to him. Yet in one visit, L coalesced her psyche enough and had gained enough trust to explain something of herself to the chaplain. She offered a story that she said her father had told her. It was actually the old joke about a group of Christians touring Africa and wanting to see lions, but getting too close and the lions began closing in on them.

One in the group hoped out loud that the lions were Christian lions. At that point, one of the lions sat back and said, “O Lord, thank you for this food that you have provided for us.” For L, this old joke meant that she had better not trust anyone. Even the brief glimpse into this powerful wall of protection, this noetic block, that kept L from knowing her own truth through trusted community, was a part of that very wall breaking down. Bolen’s focus on listening for soul level needs gives yet another lens with which to view someone with mental illness from the role of chaplain.

### **Pamela Cooper-White: Post-Modernism and Supportive Theory**

Perhaps one of the most helpful newer voices, given her level of integrated study of the various schools of behavioral science from a Pastoral Care hermeneutic, is Pamela Cooper White. (Cooper-White, 2004) Cooper-White casts the post-modern stance in a positive light on several counts.

First, she appreciates the Heisenberg Principle as a metaphor for the pastoral encounter. This principle, that the observer affects the observed, suggests that our very intention for another’s highest good already affects the situation for the better.<sup>44</sup> It also suggests that neutrality and detachment, a pervasive myth of the clinical era of both psychology and clinical pastoral training, is not possible. Pursuing impossible neutral detachment damages pastoral prospects. Instead, Cooper-White asks chaplains to acknowledge all that is brought into the pastoral encounter. She calls for a deep level of self-awareness as a spiritual tool. Even such

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<sup>44</sup> Is there, in this “better” a dualism, a judgment about “better and worse”? Perhaps so, at some level. My concern for dualism and judgment, however, pertains to judgments of persons or aspects of persons as good or bad. Assessment of situations or approaches as more or less likely to be helpful to care-receivers are non-problematic – and, indeed, necessary.

terms as “counter-transference,” against which care-givers formerly received stern warnings, are seen as unavoidable. When used with awareness, such concepts are a resource for understanding the dynamics in an encounter at many different levels including a spiritual level.

Second, the very subjectivity for which post-modernism is often criticized becomes, in Cooper-White’s reframing, a positive possibility for the pastoral encounter at a spiritual level. This philosophical awareness invites the chaplain to embrace the reality that any given pastoral encounter offers the possibility for a profound spiritual connection and building of a mutual spiritual basis for conversation.

Along with adapting this more positive slant on the post-modern view, Cooper-White has eschewed the school of psychoanalytic focus that saw through the Freudian lens of ego, id, and superego. This Freudian view suggests actions of diving down and scooping out, with an expert on one side and the person in need on the other. Cooper-White has offered a different model that suggests a constant interactivity. Drawing from Object Relations, she points to the many objects that have been introjected and live in the psyche of both caregiver and receiver. She thus rejects Freudian metaphors of depth and surface. Instead, chaplain and patient are engaged in a relationship of continuous interactive meaning making. Meanings point to each other in a growing and intricate web, while no meanings are designated “deep” or “superficial.” Ulanov would agree as she asserts, “...the formlessness of postmodernism where no fixed meanings ascribe to text but only locations of meaning from certain vantage points, instead of threatening our clinical work, endorse a fact we have known almost from the beginning: that our counter transference affects what we see and how we interpret.” (Ulanov, 2007, p. 19) The challenge for the chaplain is to bring an awareness of this on-going process as well as an awareness of the mutual spiritual potential and meaning involved in the process. An

infinite number of pathways can emerge from such a pastoral encounter holding an infinite number of possibilities for building together a view of reality (or theology) that can nurture the spirit in a given encounter.

Y was a confused patient who requested a visit from the chaplain. She had exhausted the staff by her loud statements and persistent requests for various kinds of attention. I invited Y to a meeting room and she began to speak in a rambling and slurring manner about a variety of things, largely incoherent. I had realized quickly in my time on the ward previous to my meeting with Y that, given her way of being, no one had been able to see her as a person beyond the illness that she displayed. This was my beginning point with Y. Something in Y sensed my focused presence and she began to speak more clearly, my intention to engage her already bringing something from our connection. Her words began to be clear and some part of her “showed up” that engaged a compassionate part of me. The dynamic was almost of a symmetrical movement in which each brief connection created a mutual pathway such that little by little we built a foundation. At one point, Y began to shed some tears and state her wish that I had been her mother because I listened to her. Not taking the role of mother, nor denying Y’s wish to be seen and heard by another, I acknowledged Y’s feelings of wanting to be understood. Finally Y, in a few moments of coherence, spoke of losing a child when she had not been aware of being pregnant, spoke of the horror of the experience in graphic language and then wept her loss. After this intense offering, she began to apologize over and over. I continued to validate her deep sense of grief and loss. The staff called her for a meal and she thanked me with a new clarity as our time ended. As always, this story was not a miracle cure for Y. Yet our time, rife with what Cooper White would call mutual introjected roles engaging one another, provided a container for moments of connection for Y, yielding spiritual benefits for her depth of suffering.

Focus on the spiritual is not less, but more relevant for someone with a mental illness. No psyche is, in this understanding, an integrated whole. Rather it is a multiplicity of states that come together to create a sense of coherence and identity. Again, those with mental illness struggle with identity. They struggle to blend these states to create a sense of coherence. This is a more helpful image than viewing the “self” as a unitary entity. It allows the various parts of the self to remain in dialogue, informed by one another. Psychological systems built upon the illusion of a single unitary self can be as oppressive as any religious system of thought.

It is when the person in the role of chaplain can acknowledge this deep complexity of identity that she is free to be a presence that eschews negative or judgmental frameworks laid on behavior; is free not to live with an illusion that she is the knower in the pastoral encounter with the other as one who must be known; is free to listen for the messages of the soul calling for visibility and attention. This freedom reinforces and is reinforced by two areas of learning. First, the chaplain learns to trust shared knowledge and interpretation of data as she or he learns to listen at great depth. Second, the chaplain grows integrated enough to be at ease moving around within her or his own psyche, recognizing and drawing on the way in which various parts of her or his being and experience are also engaged. This allows for fluidity, freedom, and authenticity, which form the foundation for trust. Examples of the chaplain’s process will be offered in Chapter Five.

### **A Word About Addiction as Mental Illness and as an Illness of Spirit**

Carl Jung’s definition of alcoholism as *Spiritus contra Spiritum*, (Wilson, Jung, 1987) helped bring increased attention to the spiritual in addiction treatment. This spiritual focus is gaining awareness throughout the medical model of treatment. In the Alcohol and Drug Addiction treatment program as well as in the rest of the state psychiatric hospital, where for

many of the patients, addiction often accompanies other mental illness, a growing recognition exists for the need for spirituality groups allowing patients to consider what spiritual resources can help stand against the spirits of alcohol and drugs.

Currently the DSM IV has addiction listed as one of the categories of mental illness. Many states and institutions are beginning to separate the groups financially, understanding addiction to be more of a moral choice, where a person has chosen a self-destructive path. Yet everything described concerning the mentally ill from a pastoral perspective applies to those suffering from the disease of addiction, especially the sense of isolation, the struggle with identity and an intense experience of shame. A large percentage of patients in the state hospital are suffering from dual diagnoses that include some form of mental illness as well as addiction.

Addiction alone, while just as persistent as other mental illnesses, does not present with the same kind of severity as in persons with such chronic illnesses as schizophrenia or bipolar, etc. Yet pastorally, a person in a state institution due to addiction has also not found that which makes for life. They have many intense noetic blocks and few skills to deal with issues or problems. W, a patient in the Alcohol and Drug Abuse Treatment Center (ADATC) requested a chaplain and in this listening presence, W was able to connect for the first time with her depths of grief for her mother who had died four years previously.

These patients have learned few, if any, coping skills that allow them to experience success in the noetic need to give beyond oneself in meaningful work or other endeavors. One patient realized at one point in his process of learning about recovery that, "If all you have is a hammer, every problem looks like a nail." Repeated failure results in a posture of resistance and defensiveness toward the world. A short stay in a state institution cannot easily address this life-

long-learned posture of defensiveness. This wall cannot be broken through by direct means, nor can medication address the dynamic. These addicted persons have profound noetic needs.

The theory guiding the chaplain in this context of addiction is similar to what has been offered throughout this portion of this chapter on human spirituality. The central challenge is to be aware of the manipulations and the traps, including terminal uniqueness, symptomatic of addiction, while at the same time non-judgmentally holding the patient in absolute, positive regard and acceptance. The chaplain also needs to resist succumbing to a patient's denial of need, and to resist the temptation for an inauthentic religious solution to addiction (which does not connect to the person's interior experience and instead creates an illusion of control that has no staying power past the next felt crisis).

On one occasion in a spirituality group in ADATC, the chaplain offered an introduction about the way in which Native Americans take names that connect with their essence of being as it is expressed in the world. The chaplain then invited the group members to consider a name that could do this for them. R sat quietly throughout the group some of the time with his arms folded, appearing resistant to the teaching and process offered. After several people had reflected upon the names that came to them in meaningful ways, the chaplain asked R if he had come up with a name.

"I think this is stupid!" said R.

"That's all right to feel that way. But did you come up with a name?"

"Yeah. I thought of it immediately."

"What did you come up with?"

"Running Wild Wounded."

"Tell us about it."

“Well when I was young my father was not part of my life. He left before I became a teenager. My mother raised us by herself and we were too much for her. No one could control me. And so all during my teenage years I ran up and down the streets wild, getting into all sorts of trouble, drinking and doing drugs. I was running wild but I was really wounded inside. I was ‘Running Wild Wounded.’ I still am.”

As R began to unpack the meaning of his name his voice and then his face revealed his grief as he touched into the wound into his life. He then said, “I see now the reason you do this for us.” R had touched his noetic need and saw there a glimmer of hope as he experienced visibility and care brought to that normally hidden place. R’s movement holds strong potential for his recovery.

This section provides a brief description of a stance and theory for a trained caregiver who can help the addict look at the difficult and painful spiritual issues and needs that make up this disease.

### **Delusion and Fantasy: Metaphor as Resource**

One last resource for facing into the noetic comes from Ulanov’s focus on fantasy. (Ulanov, 1982, p. 36ff). While she is the central theorist for the next part of this chapter on religious resources, her integrated study of Jung also offers helpful instruction for listening to fantasy for meaningful metaphors that connect with the noetic. Metaphor as expressed through fantasy and delusion can be a significant tool to help another in the endeavor to pay attention within. Although fantasy is said to serve as a distraction from the spiritual, it actually can serve as a window into the interior by showing accurately that which does distract, while at the same time, if one is listening without judgment to hear it, revealing central noetic longings and needs. Fantasy or delusion can show the things of the immediate life that feel intolerable by means of

the images that live in the psyche. They can help assess blind spots in life that have blocked us from a noetic connection, to hear what needs healing, needs a chance to grow and to be lived.

To notice the fantasies or delusions living in the mind is to have another kind of lens, another hermeneutic if you will, through which to see noetic longings as well as the potentially trivial that lives behind most of what one believes to be central and sustaining in life. This noticing provides a threshold to enter the depths and to encounter (and perhaps enjoy) our illusions and fantasies, while nevertheless revealing their illusory nature. Through this process one eventually is able to engage with a more realistic picture of the person in or before us. Fantasies, illusions, or delusions can, when heard and validated for the metaphorical reality they contain, offer an opportunity for healing of psyche and soul.

One patient, A, told the following story to me. Prior to coming to the hospital, A reported she had been trapped in a building with many rooms. She was able to survive because the waters of Mamre would come bubbling up through the floor from time to time to help and nourish her. Eventually she was able to get out and to free some of the other people in this trapped place, but they caught her and brought her to the hospital. Rather than challenging any of A's delusional fantasies, I allowed them to serve as metaphor for A's varied experiences. She was describing in powerful metaphor the trapped state she experienced when forced to live in a retirement home chosen by her children. She also was naming the spiritual resource in her delusion or fantasy that helped her to face into despair. Over the following days and weeks, those resources became more and more manifest in A's healing process.

This process of facing into a noetic block and finding one's own wisdom through fantasy and delusion or illusion may well sound complex and only for persons with a significant level of education or privilege. Yet the process can be powerful for a host of different persons of all

walks of life. To one spirituality group I led in the hospital I offered the phrase, “I’ve kept it all these years...”, and invited the participants, four men either disabled or homeless, to say if anything came to mind. After some initial joking about wives, B, a man in a wheel chair said, “My pain.”

I asked if B wanted to say more about that. B spoke in an angry voice about his leg having been shot off twenty-three years ago and how this loss ruined his life and how he has never been able to accept it. In his deep grief turned to anger, B isolated himself, pushing away everyone who might have been a support for him, holding onto only his pain. The other men took B’s opening statement and used it to speak of the pain they each were living with, one with terminal esophageal cancer, one with constant pain in his jaw from his own experience of being shot in the throat, and one who had just had a great deal of work done by the dentist.

As the conversation continued, each articulated in some form or fashion how their pain caused them to withdraw from life and use a chemical. B, initially angry and resistant to any naming of that anger by another, began to be able to acknowledge and articulate how he had allowed this huge loss to take away the potential of his life. He saw how stuck he was in his regret about this loss and how that regret prevented him from making any other choices besides his anger and resentment and bitterness. While this one group may not have changed the overall quality of B’s life, it did give him time and space to share his anger and noetic pain. By the end of the group his demeanor had changed and he had formed a fragile sense of community with this group. He appeared more relaxed and began to smile more.

### **Concluding Remarks to this Section**

This area of Chapter Four has sought to offer theory and examples that serve as potential resources on human spirituality for the chaplain. I have sought to illustrate that many resources

of spirituality exist that are not tied to any religious tradition or any specifically religious understanding for that spirituality. The central hope for the role of the chaplain in utilizing these resources is that the gap of isolation might transfigure into moments of connection – that a space in between self and other might open up for the expression of noetic need. In order for this to happen, much more than learning about these resources is necessary. Significant personal preparation is needed before a chaplain can bring a presence that can hear the noetic need living within the stories and experiences of these patients. In this preparation, the chaplain moves through a process of integrating personal identity and life experience, a process of growing awareness unto integration of one's being with one's faith. The ability, awareness, and insight to connect to one's own noetic need are imperative.

Not all spiritual care is equally effective, or automatically translates into care for the soul. A patient waits, often without knowing it, for someone who can hear her or his soul level need; hear it in such a way that experience can be integrated leading to meaning that will sustain the soul. This, then, is an understanding of spirituality to guide the chaplain in working with the mentally ill. This description now allows theory that connects with religion to be described as it is both connected to and separate from spirituality.

## **Part II - Where Religion and Spirituality Meet**

### **Prayer and Images of God**

Having looked at various theoretical resources by which a chaplain can approach spirituality apart from a religion, I turn now to spirituality as it is connected with religious concepts, symbols, and vocabulary. Religion can provide a healthy and helpful container for

spirituality.<sup>45</sup> Ann Ulanov is the central theorist for these resources. Her work brings fresh understanding and connection to tired religious symbols. Her wisdom has given me eyes to see and a grounding to stand on as I have moved in the realm of the psychiatric hospital. Her image of the gap, described as a gap between the unknown self on the one hand, and the unknowable provinces of God (or the Mystery, or Source, or Spirit) on the other, (Ulanov, 2001, p. 140ff) inspired in me this central metaphor for the chaplain's role. The following theory offers a window into the pastoral possibilities for some of the central resources of religion, especially including prayer and the ways in which we image the Divine Mystery.

### **Prayer: Connecting Spirituality and Religion**

When new students come to a practical training ground for ministry, often they wonder how and when they might say a prayer with patients. Their understanding of prayer considers

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<sup>45</sup> The religion I'll be talking about when specification is called for is Christianity in all its many forms, and, to a lesser extent, Judaism. This is the religious tradition in which I have been immersed since birth, in which I am trained, and which, in varying degrees, has shaped the lives of a majority of the patients in US mental hospitals. That said, I believe the basic approach I describe can equally well be taken within the context of Islam or the non-western religions. All the world's religious traditions include "holy stories." It is helpful for the chaplain to know something of the holy stories of the patient's religious tradition, though not essential. The chaplain that doesn't know, for instance, the story of the Bodhidharma's meeting with Emperor Wu, can nevertheless work with the patient's re-telling of the story. The indispensable skill is the ability to walk with patient and story together – to stand, as it were, in the gap between the patient's story about him or herself and the narratives with sacred significance for that patient – and help explore possibilities of meaning, allegorical or otherwise.

spoken words of prayer by the pastor as the norm for prayer. Yet the chaplain's role also allows for attending to prayer at different levels of theory and spirit, and of psyche and soul. An integrative model of prayer stands at the threshold between psychology and religion.

### **What Is Prayer?**

Prayer, in this integrative model, is any expression of need or longing, any wish for help or understanding or strength, or any expression of gratitude for, or feeling of abundance from, existence as a whole. A sculpture or painting can be a prayer, as can a song, or symphony composition. A prayer can be a dance, a hug, or a tear. Whenever and however we express need or gratitude, whether we do so consciously or not, we are at prayer. (Ulanov, 1982, p.3ff)

Conscious prayer is attending, noticing, listening to and seeking to hear the self. Prayer is confessional in that it involves telling the truth about oneself.

Again and again, in the psychiatric hospital, patients speak out their wish to go home, their wish for someone to listen to their frustrations. They express their need for connectedness, for another person to hear rather than ignore or challenge the delusions that are their reality; to hear their names, their identity. A well-trained chaplain lets go of the anxiety that would hear these longings as problems needing solutions. She listens with an understanding of religious potential. She hears these deep desires as prayer and can glimpse the struggle they represent of the patient's need to connect to and to offer bits and pieces of one's self.

Prayer at its beginnings in a person is pre-conceptual. It emerges from an experience of need and reaching out in the dark. If a response is offered back, trust and a resulting gratitude

can develop.<sup>46</sup> If no response is offered and a person remains in that sense of darkness and unfulfilled, then the person feels diminished. Because both are part of the human experience, both the emptying and filling moments, they both are part of what can, if attended to, if integrated, allow the coming forth, the genesis of a spiritual world. Prayer is often expressed in pictures or through emotions or as wishes that live deep within. Spoken prayers in church or at bedtime can be the least of prayer. They can at times even remove authentic connection with the self, can hide and diminish hope for a spiritual life. Unless words are used to gather the authentic images and wishes and emotions living within, images that represent prayer, they are of little help. More to the reality of prayer are the stories and the memories, the deep joys or the irritations. Harbored within these words are the authentic prayers that live in one's being with integrity and wisdom.

### **Bringing Presence to Prayer**

Hearing and bringing awareness to prayer is one of the most difficult tasks of the spiritual life and of the work of chaplain. Students wonder what purpose they serve as a chaplain in a religious role if all they are doing is listening. It seems to them that anyone could listen. But listening for prayer that is the extension of the patient's spiritual world requires keen attunement to God, requires intensive integration of their formative academic and theological training, requires a deep trust in the Mystery that lives in the patient as well as in the chaplain, requires faith. Staying present to the person living at the center of someone covered with a severe mental illness is one challenge. Believing in and staying present to God as being at the center of the

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<sup>46</sup> Ulanov connects with Object Relations, Erikson, and others who focus on the importance of these early experiences for perception of the world. Yet she also focuses her theory on one's sense of relationship with the Ultimate or God. (Ulanov, 2001)

pain and struggle of the daily life experience of those with mental illness is another.<sup>47</sup> This difficult task juxtaposes hope and fear, in the chaplain, and doubtless, in the patient.

Facing these dual challenges, the chaplain stands as a representative of the Other; offers the possibility that through his presence, a patient might experience response to this act of reaching out. Also, the chaplain stands as witness that a person lives at the center of even the most ill of patients.

J was a chaplain in her early twenties working on a skilled nursing unit with highly demented patients. I went on this ward with her for one of her supervised visits. She walked right up to one patient who was sitting in a wheel chair and in a most natural way spoke with her, “Ms. O, look! You have had your hair done and your nails painted!” Then she invited O over to a more sunny area where J knew she liked to sit while she visited. J’s approach was highly respectful, especially given the lack of assurance of how much the patient could understand. It affirmed in faith a person deserving of great dignity.

Seminarians and pastors often bring a perception that their role is to tell people things rather than invite reflections. Beginning interns, even if they have articulated the need to listen to

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<sup>47</sup> The holy wholly Other; the Source of healing and wholeness which we call by many names; the ground of being; the oneness of reality; the ultimate worthwhileness of the universe even in the midst of pain, torture, violence, tears, screams, death, loss, and all the anguish in the world; the lived relation between ideal and actual; the creative power that operates in human life to bring about transformation; love. The patient’s conception of God may be, and typically is, both supernatural and person-like (i.e., an entity that knows and desires). The chaplain, likewise, may have such a conception. Yet that to which chaplains must be keenly attuned need be neither supernatural nor person-like.

patients, often think of listening as a preliminary strategy and understand their role as ultimately bringing the “truth.” They are religious experts with answers. When they hear this way of pastoral care described early on in their training, they wonder how their role has anything to do with God or their beliefs. Yet as they move amongst the patients and begin to let go of prior notions of what they ‘should’ be saying, these students begin to see the power of listening and begin to hear the prayer that is contained in what is said and (maybe especially) what is not said. Through recognizing and attending to the patient’s prayer, however expressed, the student’s veneer of religious assumptions gives way to authentic human connection. Their own sense of shock at this way of inhabiting a role of chaplain also might be a prayerful indication of the lack of listening presence in the students’ lives.

Earlier I suggested that symptoms of mental illness be seen as attempts by the psyche to be visible or to move toward wholeness. Symptoms of mental illness are a desperate bid, a prayer for healing by the psyche. Even with a severe and persistent mental illness, connection with images that inhabit one’s interior landscape can strengthen the sense of identity that allows the possibility for connection with Something or Someone More. Prayer is a language of the soul and can shift the patient from the isolation of gap into transitional space of connection.

W is a patient with severe and persistent schizophrenia. He occasionally came to my office from his rehabilitation ward. His conversations involved a third unseen presence, the voices that lived with him consistently. In one visit, W requested Genesis be read to him. His comments on the initial chapters especially focused on appreciation of God’s creative aspects. During the Adam and Eve story, his face took on a painful look and he acknowledged that this is where everything messed up. W’s clear lament at the confusion that lived within him when a rib was taken from Adam expressed powerfully his lost self and lost interior. His ability to lament

that loss through story was a powerful expression of prayer that allowed him to leave my office with a greater sense of peace for that one moment.

T was another long-term schizophrenic patient who often came to my office. T's questions presumably made sense to him – yet often to no one else. Listening for any logic was not helpful to T. But listening to his body language and tone allowed his prayerful hope and need to enter the room. For several visits he began his time with a plea, “Tell me about the lamb.” Then T spoke in his confused and rambling manner. On subsequent visits he revealed that he was Jesus and he spoke often about how Jesus was treated awfully and wounded and beaten. One visit, T opened with his usual question, “Tell me about the lamb.”

I responded, “The lamb still has the scars.”

Tears came to T's face for one intense lucid moment. He said, “Thank you.” He then left, having had as much visibility as he could handle at one time.

The days of listening, his use of the religious figure of Jesus to tell his story of a life of violence at the hands of his father, his plea for me to tell him about the lamb, all were prayers seeking visibility and self. And in certain moments the prayer brought connection unto care.

Prayer is not a miracle cure for mental illness. The mental illness of patients in a psychiatric hospital is almost always painful and chronic, and often ends in death. Yet moments such as W and T experienced point to the power of prayer to facilitate visibility and integration and connection with one's interior. From the medical and quantitative perspectives, we might note that these moments of connection are often short-lived and do not lead to a “cure.” From the spiritual, pastoral perspective, which affirms *being over results*, these moments are invaluable in themselves. (Being able to maintain a perspective such as this is part of the chaplain integrating pastoral authority.)

Moreover, even from the medical, quantitative result-oriented perspective, experience of connection and identity in the “eternal now” of a particular moment often does correspond with the easing of symptoms. If interior realities are given space and presence, then prayer also creates anticipation or hope in life. When a patient has experienced another (and so Another) attending to them and noticing their hopes and dreams and longings in life, those hopes and dreams have more reality, and rise from the graveyard of dead concepts into the playground of live possibility. When the self and the interior reality is ignored or denied, then those hopes and dreams are either meager, without great energy or anticipation, or they are so improbable as to be disconnected from any reality. When the self is unreal, interior reality denied, hopes cut off, only delusion remains.

One chaplain working with men in the addiction center repeatedly heard these men speaking out their frustrations or asking questions that seemed to have no answer. Rather than hearing these questions of great angst as seeking specific answers from her as a religious “expert”, she heard them as the prayers they were. One patient in great perplexity asked how he could get his family to trust him again.

“Exactly,” said the chaplain, affirming the prayer rather than answering the question. Simple as it seems, this non-anxious reply was highly validating to the painful reality of isolation experienced by this patient. He felt respected by this visibility and validation and was able to find a connection within.

Listening for prayer can be deeply challenging. Z, a patient in the alcohol and drug abuse treatment program, was attending a spirituality group I was leading. Z walked out of the group in anger when he heard someone articulate a struggle of faith that involved the scriptures. After the group ended, I went to check in with him. Z spoke of his grandmother who raised him and

her deep love of the Bible. She had died in the past month and in his grief, he connected her with her love of scripture. Struggles of faith and scripture voiced by another patient in the group brought this Z's grief to the surface. As we talked about his loss and the connection that brought up that loss, Z became aware that his strong need to leave was his prayer expressing grief and loss, and furthermore, that his leaving from the group was symbolic of the way he had been disconnecting from himself and his feelings by taking drugs. Connecting to the source of his strong feeling allowed the prayer and response to become conscious and allowed Z to connect to his interior. Z was able to shine some light of self-awareness on his grief and loss and the deep pain that was a significant part of the reason for his substance abuse.

This level of attending to prayer requires openness from both patient and chaplain. The chaplain must bring an open presence and listening -- ready, without prejudice, to hear what is said for clues to the patient's interior. The patient must, at some level, conscious or not, feel a call or tug to take that risk of inviting another into her interior, even if only in a small way. This openness suggests that the religious process is not about struggling to come up with some posited external 'will of God' or some objectively determined response of the heart or soul. Such objective responses may, in fact, destroy the life of prayer in another.

In one Sunday service at the hospital, C, a patient, was listening to a sermon and heard one part that was powerfully meaningful to him. Amidst the other occasional 'Amen's' around him, C added his own heartfelt, "A-fuckin-men". This response would not be acceptable in many churches, yet for him it stemmed from heartfelt prayer, albeit representing strong feelings of anger mixed with potential. A chaplain willing to bring presence and listening will not be distracted by form or vocabulary. She will notice and then let go of inner resistance to such forms of prayer. She will need a depth of self-acceptance in the efforts of listening for prayer.

Even in the midst of wrestling with resistance and willingness, this attention to prayer allows space for both person and listener to accept and respond to the deep longings of the soul.

### **Prayer as Connection to Other**

The chaplain's listening process fosters the possibility for belief by the patient (and chaplain) that an Other in the form of the Divine Mystery is present, that there is an Other for us. This desire and resulting awareness is at the heart of spiritual experience, and is the beginning point for religion. Many lesser desires or yearnings cover the Ultimate Desire for connection or union with the Other. In assessing a gap experience and the yearning connected to it, the chaplain is recognizing the desire for fulfillment of what the Gospels refer to metaphorically as "The Kingdom". Many of the kingdom parables express this yearning; the pearl that is of greater worth than all earthly treasure, the coin that, when found is a matter for great rejoicing, the field that one will gladly pay all to have. Longing expressed by patients often gives a true picture of their own image(s) of kingdom. Also, the first beatitude speaks to this mystery of prayer, that our very awareness of our spiritual poverty, of our need, is the central possibility that lives in prayer.

Through fiction C.S. Lewis expresses this same dynamic of prayer. In *Till We Have Faces*, he writes of a queen who experiences a painful and tragic loss at a young age. (Lewis, 1956) Her sister is lost to her as a sacrifice to the gods. In trying to rescue this sister, the queen herself becomes the tool of her sister's destruction. She becomes angry with the gods and much later in life, is given a time when she might speak out her complaint against them. But then the time does come for her to face the gods and she examines her complaint focused on the religious system of the gods. She discovers that she has no real idea of the personal spiritual need and deep grief, at both the loss of her sister and her own part in that loss, which had been living in

her soul for all the many years of life. It is eventually the gift of these gods that she touches into and is met in her depth of pain.

Prayer is the language in which one is able to shift from an unknown longing to a place in which longing begins to have a form or image. In that process, the Ultimate to whom the prayer is offered also then begins to take form and image. (Ulanov, 1982, p.7) The soul-level need begins to be glimpsed on rare occasion; light begins to emerge through a momentary chink granting some level of understanding. Learning to understand the language of prayer is a difficult and painful integrative process in which a long, sometimes decades-long, time of sifting and sorting and learning goes on at a variety of levels. Seldom does any person actually become so fluent in that language as to consistently hear another clearly or easily. Therefore, prayer also is struggle. It is the very struggle to hear oneself, to become conscious and honest about the voice of longing that lives within. Learning to hear one's own voice, as a chaplain must, creates the possibility of hearing another's voice, the deepest longings and hopes that live in the depths of the soul.

N is a patient who was brought to the hospital against her will in a sheriff's car. She asked to speak to the chaplain, and I was paged. She immediately asked me to get her out of the hospital, assuming that chaplain had the power to do so. When I said I could not do that, she was angry. "Then what are you good for?" she spat out at me. "What can you do?" I said I could stay with her and listen to her. She began to shout, saying that was no good and asking again what I could do for her. I acknowledged her anger and repeated the offer to stay and listen.

After a few more similar exchanges, and then some time of quiet, N suddenly burst into tears. She talked about her father who had died a few weeks before. She said she couldn't stand how it felt to lose him, and she had stayed on drugs since that time. She wept through that huge

wave of feelings and grief that she normally blocked from herself. Her energetic wish to leave the hospital was a wish to distance from that huge approaching wave of grief that she had no one to listen to or help her process. I didn't say a prayer with N. Nor did she ask for a prayer. But her wish to distract from, and her deep struggle in connecting with her sadness and longing and grief was prayer at a profound depth. This way of being that sees prayer as attending to the depths of longing offers a way to live the metaphysics that is God, a way to experience God rather than positing beliefs about God.

Even as presence in the gap turns gap into transitional space, presence to prayer (the longing deep within) turns a felt disconnection from the heart or soul into a threshold, a place of entry, a passageway, a connection between one's interior and Something More. Just as the deep thresholds into the Celtic Churches in Ireland invite noticing of the transitions into and away from these places of worship, so does noticing one's interior allow prayer to be a way of transition and connection.

### **Images of God and Prayer**

In the context of one of the men's spirituality groups in ADATC, the chaplain works hard to listen for the various images of God held by these men, and how those images connect with prayer and other spiritual or religious endeavors that might aid the men in their recovery. When these patients are invited to consider their image of God, they often recognize two pictures of God that live in tension within. One image is of a grandmother who often helped raise them and represents the combination of loving concern and clear expectations they experienced growing up. The other image is that of the judge who sent them to the very institution where they now find themselves. Coming to find their own harsh judgments standing next to the picture of care gives them a greater connection to their felt needs. It also helps them see what lives behind the

judgment that pronounces them wanting and sends them back to escape in a given drug over and over. The image they choose in the entrusting of themselves through prayer can carry great power of potential for or against their process of recovery.

From the perspective of Pastoral Psychology, the images of God that live in us offer both opportunities for pastoral assessments and ways to consider the gap experience for others. These images coordinate with our experiences of longing and provide ways that we can connect with that which is beyond all imaging. They are most important to become aware of as these images are that to which we are entrusting our prayers and our very selves in prayer. Freud would suggest that these pictures or images are ways we deceive ourselves; that they need to be destroyed in order for persons to come to maturity. But Jung called Freud's approach into question, suggesting that in his approach to his theory, Freud is responding to his own pictures of an Ultimate. (Jung, 1973, p. 151)

The chaplain working with persons having mental illness must learn both to be aware of the many images that inhabit himself, and to listen for the images that inhabit another. To destroy or shatter these images only represses them. And the repressed inevitably returns (Freud was right about that part). Repressed images live on through unconscious experience, resulting in either depression in oneself or projection onto another person or group or culture. Connection with images does not happen quickly or easily. The chaplain's work is to constantly RSVP "yes" to invitations to a new level of self-awareness.

A chaplain's receptivity and openness helps patients experience something beyond the internal images that live within, no matter the culture or religion that is part of that individual's history. This is different from trying to reach for a religious experience for the sake of experience. The very reaching for that experience prevents it from happening. Helping people

connect with those images becomes especially challenging when they hold an internalized expectation for what the image of God ought to be. The chaplain in this instance listens for that which emerges from the smallest chink in the wall of imposed belief.

Our Department of Pastoral Care offered a washing and blessing of the hands to staff as one way of acknowledging the department's 50-year anniversary. Over two hundred staff from all walks of life and faith came to have their hands washed and blessed. One staff person, D, said that she did not believe in God and she asked that we offer thanks for her hands rather than a blessing of her hands. Yet as a chaplain washed D's hands and expressed gratitude for them, tears streamed down D's face. She experienced an Encounter that was powerful at the point of spirit and of re-ligion, of reconnection with Something More.

### **Listening for Images of God in Prayer**

The chaplain's task is most definitely not to make a religious experience happen. Rather, the chaplain listens for and stays present with whatever images emerge, especially for those images that have the power to sustain the patient through crisis. This listening for and engaging with images can eventually create a way in which an experience of Love that Lives at the Heart of the Universe can inhabit a gap that has opened up, and can allow that gap to become transitional space in the fullest sense.

Pastoral Psychology helps one in the role of chaplain serving those with mental illness connect to such images. Other disciplines, especially in a psychiatric hospital, are only able to assess whether an image held by a patient is normative to her history, or is a delusion. However, the chaplain assesses the image for the way it impacts the patient. Out of that assessment are several options: The chaplain might simply consider how to bring presence to someone with such an image; the chaplain might consider how to help someone integrate the images that live

within; or the chaplain, seeing that a given image was externally imposed (typically from the patient's religious tradition) and internally introjected, could consider how the image's grip might be loosened.<sup>48</sup>

Offering an example of the second option of integrating images, a chaplain was called by a doctor on the Adult Acute Unit to assess Y, a patient who said someone had "worked roots" on him. As the chaplain listened, it became clear that this religious understanding was not a part of Y's mental illness. Rather, Y came from a part of North Carolina where "roots" (understood as a kind of negative hex) was a normative belief that Y articulated clearly. With the staff's consent, the chaplain devised and with the patient engaged in a ritual of healing that held prayers of empowerment in the form that this patient understood, that engaged an image of God with the potential to stand against the power of the "roots".

Examples of images that keep a patient sick are common when the "spirits" of alcohol or drugs are involved. Patient X claimed that a demon made him take drugs. On its face, X's claim was similar to Y's. Because demons were a normative part of the belief system of X's religion, the staff felt stuck as to how to approach X and called the chaplain in for assessment. It became clear to the chaplain that, while demons may be a part of X's belief system, both the disease of addiction and the psychological impetus to make excuses for addiction were active in X. This allowed the doctor to consider what treatment would best suit X given the dual diagnosis. It also allowed the chaplain to notice various mixed messages as a way of caring confrontation that

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<sup>48</sup> Again, the aim is not to destroy or shatter the image, just to loosen its immobilizing grip enough for some wiggle room. With space for movement, patient and image can creatively wrestle/dance together.

could help X shift from the magical thinking about his addiction that didn't allow for any hope of recovery.

### **Pastoral Assessment and Images of God**

As noted previously, the chaplain role is distinctive in the mental hospital. While other disciplines can only assess whether a given religious understanding or behavior is normative for a person, the chaplain can consider whether the patient's religious images, normative or not, contribute to the patient's illness. Ulanov's work has suggested a way to integrate Object Relations (OR) to help with this assessment. She has suggested two major images or pictures, the Objective Object picture of God and the Subjective Object picture of God. (Ulanov, 2001, p.22ff) The former she means as more traditional pictures of God. The latter emerge as subjective experience and projection gives life to these Objective images. Neither, suggests Ulanov, contains the full picture of the Ineffable.

These Ulanovian concepts led me to consider how to assess such images in patients suffering from mental illness. In making my own meaning and use of her concepts, I have considered various levels represented by her overall OR images as they apply to such spiritual assessments. The first two of four levels or categories named below connect with subjective images, the second two with objective (which also involves cultural) images.

First is the purely idiosyncratic, individual, personal, private. This level or category includes images, dreams, ideas that connect with an emotional reality but are not communicated to others. An example of this by way of spiritual imagery would be the priest who, in coming to the scriptures to prepare an Easter sermon for a congregation was intrigued by an image that had previously been a side item to the real meaning of the resurrection story in the Gospel of John. She read: "Then Simon Peter came, following him, and went into the tomb. He saw the linen

wrappings lying there, and saw the cloth that had been on Jesus' head, not lying with the linen wrappings but rolled up in a place by itself." (John 20:6-7, NRSV) She saw an image of the resurrected Jesus turning around to make his bed, to roll up the head-cloth and put it carefully in its place. This sense of bringing a moment of order to the dawn of resurrection after death gave her the impetus to do the same in the morning after her own 'death' of sleep. It carried spiritual energy for her in the weeks following, allowing her to live better in a difficult period of life.

Unfortunately, persons with mental illness often do not consider these images to be appropriate, given their struggle to have a sense of identity. It takes an other, in our case, the chaplain, who can hear and validate this subjective spiritual experience to move to the next level where it can offer the spiritual energy the priest experienced.

This next level or category is the shared and integrated. If a patient can be given a safe enough container to articulate to the chaplain a meaning that had been idiosyncratic, and the chaplain grasps and validates the meaning well enough to have a conversation with the patient about it, such that the patient feels understood, then the meaning has become shared and allows for even a shred of energy of spirit to coalesce for a moment of identity.

A woman struggling with chronic depression lived with conflicting images, the one of God as similar to the malicious father she grew up with, and one of a feminine divine figure who was ready to come with help at any sign of need. She believed the latter was sinful until she was exposed to an art class that focused on historical images of the feminine divine, which powerfully validated her subjective experience. The same dynamic is true when a chaplain hears and validates an image borne of a more subjective spiritual experience, especially when the patient would not be able to claim that experience as having any spiritual meaning.

One chaplain intern learned of an image of God that he had never before encountered, an image that was deeply meaningful for patient O. Far from doubting or challenging this life-giving image held by O, he looked up the religious sect and took supportive material to O who greatly benefited from his willingness to stand with her in validation of her image of God.

We need another to help us know that our understanding of reality has validity. Through conversations with others who are tuned in to the images and the meanings described, the spiritual potential, otherwise inchoate, takes on concreteness and integrates with our identity and with all our other meanings. This integration of meaning connects us with the world. It is the way we care about something beyond ourselves. Integration, in this case through the help of a chaplain who was listening for a given image, makes meanings real, alive, and interesting.

The following two levels or categories for images are more connected to what Ulanov using OR vernacular calls the Objective Object God. The first of these is the ossified, institutional image. Over time, a well-used metaphor becomes ossified – that is, no longer metaphorical but literal. “Mouth of a river,” for instance, began as a metaphor but has come to refer literally to geographically specifiable places. In the same way, any meaning or image can come to be taken on by many people over many years. This “institutionalization” of a meaning entails a loss of the freshness and aliveness the meaning had when first shared.<sup>49</sup>

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<sup>49</sup> The emotional content, essential to the life of the meaning when first expressed, has been abstracted out. When the meaning was fresh, it was alive with creative “open questions” -- possibilities for application and expansion and further integration. Institutionalization answers or otherwise closes those questions. (This doesn’t mean that the meaning doesn’t elicit powerful emotions. Perhaps it does. But those feelings are disconnected from the feelings that were part of the original genesis of the meaning.) For example, with some effort we can construct in our

Persons with mental illness often have such ossified institutional images of God thrust upon them, not even as images, but as the literal reality of God. Unfortunately, the images used are not usually pastorally supportive ones that may still carry some helpful emotional content, such as the nurturing images of huge wings hiding and covering, or a cave of safety. Rather they tend to be highly condemning images of a consuming fire or condemning judge, quick to send persons to a terrible image of hell, again, assumed to be literal. It is because of this category of God images that it is so important that an educated chaplain stand with the more subjective though unrecognized, unrealized, unintegrated God images.

The final level and second in this latter Ulanovian category is The Objective (Object). We cannot know the objective; we can only know its manifestations in meaning at one of the first three levels. Nevertheless, “The Objective” is an important concept. It reminds us that our meanings, even when taken all together, are finite, limited, and incomplete. It reminds us that new and different meanings are always possible. We may have an image that is supported by everything we know, that stands up to all conversational challenge, that accounts for all the evidence we know of – or can imagine – yet it might not be objective. We have no idea what this “objective” might be, but it’s helpful to have a concept to remind ourselves to be open to creativity, open to new meaning. In Ulanov’s thinking, this category allows for a Reality beyond all images. (Ulanov, 2001, p. )

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imaginations what it might have been like for Francis Scott Key to be on that ship and to see his country’s flag waving over the battlements. For the most part, though, “The Star Spangled Banner” is an institution. Its meaning is to conjure patriotic sentiment. Often it doesn’t even mean that: it only means the ballgame is about to start.

By way of pastoral assessment, the chaplain, along with being aware of his own images of God, can listen to hear what images exist for the other. This form of spiritual assessment requires a non-judgmental approach to another's image. By non-judgmentally hearing the patient's images, the chaplain participates in a process of integration-through-sharing for the patient. If someone only has a private idiosyncratic image of God and doesn't hold to any sense of Something beyond her or his understanding, then that person may be limited at a time of crisis – may deplete spiritual resources rapidly without community and without deeply integrated images. Or the images that do live in this person may have been repressed and are unavailable. Repressed images usually manifest in some way.

One result of this kind of repression of private images is projection or introjection. Either the image of God is put onto some person or group of society or religion, or it is turned and placed onto some part of the self. In the former case, projection can result in highly destructive activity toward another person or group. The Holocaust is one extreme example. But seldom do those with severe and persistent mental illness have the power for such wide scale destructive power. In the latter case, introjection can result in the image being placed on a part of the self, overtaking the spirit of a given person and resulting in a loss of connection with reality, the more likely experience for those with mental illness. As Ulanov has asserted about these two ways of dealing with repressions of religious images, politics is full of projection; mental institutions are full of introjection. (Ulanov, 1982)

A second result of repressing/introjecting personal images is often depression. This happens when someone, by repressing an image, is cut off from the sustaining soul level needs and longings that live within and the energy that they offer for life. If an image is not tolerable to the conscious mind and so is sent away and repressed, or is avoided with great care, then an

avenue of connection with one's interior is blocked. This is not a medical understanding of depression. Yet many psychologists and psychiatrists have stated that depression is a spiritual issue. (Blazer, 2008) The Geriatric Unit has a spirituality group in its treatment mall led by chaplains that is for the purpose of reconnecting with spirit as a way to address depression.

E, a patient in that group did not participate for several weeks until the chaplain asked a question that allowed him to connect to the business he used to do for his life's work. E's entire demeanor changed for a short time, but then he sank back into his previous deep depression. The next day the chaplain went to visit and found that E had eaten for a change and that he was feeling much better. She asked what was going on for him. E tried to articulate his realization from reflecting on the spirituality group the day before, that he had depended completely on his work life to sustain his spirit. Once that was gone his spirit was without sustenance. However shared and integrated the meaning of E's work may have been, he now needed a new meaning. That moment of energy and enthusiasm gave E the interior space to explore and open up to Something Different, to new possibilities of meaning for his life's energy.

The chaplain, hearing this more subjective experience of Spirit, might consider how to listen for a depth of connection and meaning that sustains in times of great depletion. Or she might consider how to hear in such a way as to notice any sense of the Eternal in the midst of the immediate. Or finally, she might listen for ways in which older images long rejected by this person might be appearing in disguised ways in a given pastoral situation.

On the other hand, a listener may hear only an image or experience of an Objective Object God. This is most often the case in a hospital for those suffering from mental illness. A person's unique spirituality is not allowed to develop. Rather, fearful images are planted over the spirit through an oppressive religious agenda from an external belief system, regardless of the

spiritual needs of a person. The resulting guilt and fear can be crushing of spirit. This dynamic happens when a person or community of faith has given their image of God a status of being ultimate, insisted that this image of God *is* the full and concrete and total reality of God, and placed that understanding on a fragile psyche of someone with mental illness. (In religious language this would be called idolatry.) When this happens, persons no longer honor the various images living within them and they must reject another's images or pictures of God. They also deny the possibility for living with ambiguity or tolerating others coming to different understandings or images.

Ulanov writes powerfully of the story of the women who stay at the cross of Christ. As they stay, their various images of who they hoped Jesus to be were shattered. (Ulanov, 2001, p. 141) In allowing that shattering, those women have the potential to experience Something beyond all of their images. Such waiting for a new understanding to break through is not only a patient need. Chaplains, too, must wait in the creative silence from which new meaning/life resurrects. Otherwise, the images of God that the chaplain might want to impose on a patient also will serve as the same deterrent to the possibility of Something More.

V was a patient stuck in a cycle of prostitution. V's confessional stance and her judgmental image of God were uncomfortable for the chaplain intern who went to visit her. The intern instead substituted her own external image from the teachings of one of her feminist seminary professors. It had struck a powerful cord for this intern but had no connection with V's meanings, experience, life, or identity. Had there been any ground of connection, the proffered image would probably have been more "healthy" for V. Nevertheless, it was not an image that

was authentic to her, or that could be integrated by her in the short time of her stay.<sup>50</sup> The intern had to grieve her inability to confer her image to V, as well as her powerlessness to make V find a different system of belief, even as V grieved her own powerlessness to change her experience. It was later in meeting in this place of mutual, if unspoken, grief that V felt the deep care of this chaplain and new possibility for her life out of the parallel experience of God's forgiveness.

A chaplain can approach traditional images by considering various questions. How might I listen for the unique spirituality of this person that has been squelched by imposed religion? How might I stand with an authentic part of this person whose isolating gap experience of illness or loss is complicated by potentially oppressive religious images and understandings?

In a spirituality group with the women on the alcohol and drug abuse treatment center, a chaplain recognized this dynamic as the women explored possible resources to help them in recovery. Almost to a person these women had been raised in churches that demanded strong conformity to an image of a condemning male God who would send them to hell for any behavior that didn't tow the line stipulated by the preacher. So in order to invite some of their unique spirituality as a resource, the chaplain first asked if any of the women had nicknames, invited them to write down those nicknames. Then she invited people to tell about their

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<sup>50</sup> In this case, the important feature isn't that the image is "official," institutionalized, and therefore inauthentic. We need not venture into the question of whether this particular feminist understanding has, in some sense, ossified into an institution within certain subcultures. The important point here is that integration requires one end grounded in the personal even as the other end is grounded in encounter with others. An external meaning, whether institutionalized or not, may well, as it does in this case, lack grounding in the personal.

nicknames and the stories connected with them. Remembering and offering stories of these bits of identity generated a lot of energy. Next, the chaplain invited the women to consider nicknames for God, things that might express who God could be. Again, energy and creativity brought forth a host of names that held a variety of images connecting with the needs in these women: ‘Creator’, ‘Morning Star’, ‘Mother’, and many other names. These images opened up the women both to possibilities of support and to the needs living within. This connection with the unique spirituality living within each of them allowed their sense of religion or spirituality to gain some life and gave to these women a resource for their recovery.

If chaplains are not able to stay present with, but are threatened by the patient’s images of God; if chaplains prevent patients from expressing their own images of God, their unique spirituality and the unique way in which their soul is energized, then chaplains can cause more harm than help. They may contribute to repression unto depression, or the idolizing unto rigidity and oppression, all to the detriment of heart, mind and soul. Again, this is often the plight of persons with mental illness as they have succumbed to oppressive images presented to them.

The alternative to these two potentially harmful ways of dealing with images of God, these ways that both represent running away from our deepest being, is to accept or help another accept the images that inhabit us, images that live in us as real images; (Ulanov, 1982, p. 31) to embrace a process of integration of these images for the depth of richness in our soul and a resulting energy of spirit in the world. The process invites us to bring all our names for God into our praying, into living the attentive life. This is deeply challenging to persons who have been schooled in a particular theological tradition that claims the perspective of the Ultimate. For instance, when a patient, R speaks of God as a God of vengeance and prays to this God to bring retribution to the persons who put R in the hospital against her will, the theology student

listening feels a great discomfort and wants to shift this image, this understanding of God. That student struggles to hear and be present to the pastoral issue lying beneath R's image, the level of anger and pain living through the image and so resists standing in the gap represented by the feelings of betrayal and anger that create that vengeful image of God. Yet when these images can be accepted, if the chaplain intern can validate the feelings living within the images by naming the painful betrayal that R has experienced, they can become a place of meeting, a place of opening up to the depths, in this case of pain and betrayal, allowing a sense of connection and a fresh wind of spirit to inhabit the deep places within.

This way of viewing and understanding prayer and images of God offers a strong foundation from the discipline of Pastoral Psychology to support the chaplain. It offers a way of listening for the prayers that live in a person's heart and soul and reflecting those back for help and healing. It offers a way of listening for the images of God that live in a person, reflecting the sense of self and identity of that person as well as her or his aliveness or deadness of spirit. Finally, it invites the chaplain to hear such themes of aliveness and deadness within herself. (Ulanov, 2007, p. 73ff) Prayer and images of God, when understood in light of the theoretical frame I have outlined, are religious resources empowering the chaplain to stay present in the gap with another person, remaining non-judgmental and making visible and real the religious and spiritual experience that might become a resource for energy and healing of soul and spirit.

### **A Word About Answers to Prayer**

What about the possibility of our prayer, whether spoken words or interior longings, being answered? Poet Rainer Maria Rilke offers this reply:

“Be patient toward all that is unsolved  
in your heart.  
Try to love the questions [prayers] themselves.  
Do not seek the answers

which cannot be given  
 because you would not be able  
 to live them.  
 And the point is,  
 to live everything.  
 Live the questions now.  
 Perhaps you will then  
 gradually,  
 without noticing it,  
 live along some distant day  
 into the answers.” (Rilke, 2000, p. 21)

In this sense, the answers to prayer live all around and in and through us. This is not meant to diminish the deep desires, nor to discourage the prayers or the faith that the prayers are heard. It is to invite eyes to see and ears to hear the possibility that in faithful living, these prayers are opening us to a fuller way of life than we might ever have imagined, are taking us beyond the agendas others have for us or that might trap us from that promised abundance of life. And it is to encourage mature people in pastoral roles to help those who seek help to find a safe container, to have someone to explore with, someone who will stand in a gap of longing and isolation as this process of living into prayer emerges.

### **Prayer and the Preparation of the Chaplain**

It takes a profound person of prayer to hear these prayers and images, both in the self and in the other, and know them for what they are. It takes a person who has faced into his own places of fear, become profoundly aware of his own powerlessness, to be able to stand in the gap with another without judgment or a need to make something be different. It takes a profound level of trust beyond the normal way of control to stand with a person in such a way that the gap can become transitional space, can allow a renewed sense of connection.

The main temptation for a chaplain when standing with another who is afraid, is to offer reassurance. Yet this reassurance seldom holds any real presence. It comes from the chaplain’s

anxiety, and is her attempt to make something better in the moment that can't be better.

Reassurance is usually a flight from the immediate struggle or into a false struggle to avoid suffering. It sends the message that, "This pain or longing is too difficult, too painful for me to look at, so don't you look at it either." It is hugely difficult to face into these kinds of places over and over again with persons in the midst of painful poverty of being and not at times succumb to the inner desire to "make things better." The problem is that it doesn't create a container for eventual healing, and leaves the person stuck in the gap. It doesn't allow for redemptive suffering in which the pain can soften and eventually create a wider space of life. While it is important to be non-judgmental of the care-giver in the same way as the patient, it is also important to help that care-giver relate to her or his own zones of fear.

This concludes the articulation of a theory that integrates religious themes and actions into a foundation for a pastoral stance with the mentally ill. Central are the images of God carried in the psyche and soul of each person, patient and chaplain alike. Also central is the way of offering or entrusting oneself to a given image. Listening for images and for the prayers that connect with the depths of soul and psyche of a person gives the chaplain a powerful tool for standing in the gap with a given patient.

This chapter provides a theoretical base for the chaplain in a pastoral model of spiritual care – a model for working with the life narrative and experience of those having mental illness. This pastoral model stands alongside the medical model, and stands in opposition to religious models that posit God or a particular belief system and bring that system to a given pastoral encounter. Even as persons with mental illness are exaggerated mirrors of each of us, this same theory and model is also a guide for spiritual care for all persons.

## Chapter Five

### Conclusions: Theology and Formation from Theory

Chapter Four offered integrative theory to support the chaplain in ministry to those suffering from mental illness. This chapter explores two central conclusions from this theory. First, if such a theory and integrative process is to be realized, the theological foundation of the chaplain is of great import. Second, the chaplain's formation process must mirror, must be congruent with the foundation of theory offered if the ministry is to have integrity.

### Theological Underpinnings for Pastoral Psychology

Historically the word "pastoral" emerged from the institution of the church, from a theological realm. Pastoral Psychology, as it serves as guide for ministry, is inherently theological. By its very nature, the role of chaplain is inhabited by those who are theological in their identity, training, understanding and in their approach to their role. Therefore, theory that supports the chaplain, requires a theological foundation.<sup>51</sup>

My central resource for that foundation is Maggie Ross, an Anglican Solitary with a prophetic voice for integration of life experience as a spiritual way. I read Ross through three hermeneutical lenses that support her thought. The first lens is Celtic theology that embraces Creation as a starting point for theology more than the sacrifice of Jesus, and begins with experience over religious agenda or academic articulation. These two tenets of the Celtic

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<sup>51</sup> I remind the reader that I come from a specific tradition that is Christian and Anglican. I do not assume that all others must adopt this theology, but that any theology, Christian, Buddhist, Jewish, Islam or other, that can support chaplaincy to those with mental illness must be experiential more than dogmatic in nature.

approach result in a gentle and respectful way of theology and offer a critical purchase for Ross' material, which she offers in a highly intellectual way. Her passionate and prophetic voice can at times belie the respectful posture her vision offers. The second lens is feminist theology. At its most succinct, feminist theology starts with experience as a point of authority for theological process and wisdom. (Fischer, 1989) The third lens is Liberation Theology, which asks that we go to the marginalized, in this case to those with mental illness, and listen to their perspective, both of their needs and their theology. (Russell, 1993, p. 21ff) The memoir written by those with mental illness and their families is an example of this starting point. All of these hermeneutical lenses invite experience as a starting point for theology. In addition, Diana Butler Bass provides a theological backdrop for Ross and these lenses of focus.

### **A Theological Backdrop for Integration**

To the question “does theology impel religion or does religion determine theology,” I would suggest that at its best, experience is a central starting point for both. Further, I would assert that positing God, through religious worship or theological study, does not allow for authentic theology or religion. Theology that tries to posit God, tries to say anything about God separate from an experience of God has fallen away from authenticity and therefore meaningful religion or theology. (Ross, 1988) Speaking about or positing God creates a constrained way of living and creates a religion that is a thin veneer of moral strictures with tepid commitment to social concern, or with fervent evangelical passion for gaining assent from others to a conceptual basis for individual salvation from a proscribed hell. Theology congruent with the theory offered here suggests that at the center of any helpful theological endeavor is engagement (with God).

### **A Theological Tension in the Air**

A theological tension exists in religion in the current culture, intensifying the challenge to a chaplain inhabiting a theological role. Awareness and understanding of that tension lends authority to the chaplain who brings a pastoral model alongside the medical model and who stands against unhealthy religious expectations. Diana Butler Bass has studied and conceptualized this theological tension. (Butler Bass, 2006) The church, in the way that it has drawn theological and behavioral lines that create division more than identity, feels like a juggernaut spinning off of the maelstrom that is organized religion. Various designations such as the religious right, the liberal left, along with all the various streams and strands within different denominations call forth significant energy spent focused on those differences.

Traditionally, differences among churches and denominations ran along the line of conservative vs. liberal. Each of these polar opposites had their theological approach creating ways of thinking about issues. Each had their hermeneutic for reading scripture. The gap between the two seemed huge and dialogue impossible. Dr. Butler Bass, researching the development of this dynamic and its effect on the church, studied the characteristics of churches that were growing. She referenced a book entitled, Why Conservative Churches are Growing. (Kelley, 1996) and suggested that while the book was a well-written and nuanced book, by and large people read, not the book, but the title. They actually miss-read the title as “*Only* Conservative Churches are growing”. Approaching her research, she initially believed that the mis-reading of the title reflected an accurate phenomenon in the country. She expected to find only conservative churches growing. But she discovered significant numbers of highly liberal churches blooming from ashes of earlier dying churches. She was forced to reconsider her assumptions.

She discovered that the growing churches could not be identified along the lines of conservative or liberal. Examples of growing churches existed from both sides of the spectrum. And the opposite was true. Dying churches existed from both sides of the spectrum. She looked for some other dynamic to explain the growth and lack-of-same. Most of the dying churches reflected characteristics of what she came to name “establishment churches”. Growing churches reflected characteristics Bass named “intentional churches”.

Intentional churches had three significant characteristics. First, they honor their tradition. By that she meant that people in these churches knew the narrative of their history and their place in that narrative. Explaining by way of opposite Bass told of a Sunday school teacher in one Church who instructed her class that, “The church used to believe *this* and now we believe *this*.” In that statement Butler-Bass suggested that the teacher wiped out any connection with history and with the larger picture of identity that the church had to offer. Rather, telling stories of the church’s tradition and showing movements and shifts as integrated parts of those stories make a very different meaning that enlivens identity.

The second characteristic of intentional churches invites intentional practice of living out one’s faith beyond the walls of the church, practicing faith in the midst of life as different from conforming to certain rules of belief or behavior.

The third characteristic of the intentional church points to the wisdom it has to offer to the world for the living of life. Especially this involves taking seriously the task of helping persons cope with experience more than overlaying experience with expectations of belief and practice that take precedent over any unique individual soul. A sense of hospitality and a discerning spirit emerged as secondary characteristics from these central three.

Those in intentional churches experienced a relational God as different from the distant God of those in establishment churches. Where folks in establishment churches focused on a piety of personal devotion reflected in kneeling and bowing, those in intentional churches saw piety as accounting of experience, of talking about faith. Intentional churches were interested in formation while establishment churches focused on information about Christianity. Finally, intentional churches cared less about the style of church and worship, and more about meaning.

This new view broadened the horizontal linear poles of conservative/liberal into an axis that added the vertical poles of establishment and intentional churches. Dr. Butler-Bass then created a three-dimensional graph, adding another set of poles that cut through the center on the other horizontal plane. She did this to add the picture of the surrounding cultural world-view or orientation by which people interpret the universe, represented by the categories of modernism and post-modern thought. Modernism is based in the idea of a single truth derived from scientific method and right use of reason. Modernism says, "We can know anything; we only needed to gain the information. We can correct anything that is not working as it should." This assumption set up dualisms of right or wrong; suggested that eventually in any conflict, one truth would ultimately arise. This view had a powerful impact on the study of theology.

In contrast are the post-modern assumptions that we can see where we have been, but can't know or control where we are going, and more especially, that no one truth exists. Rather, truths are derived from experience and the processing and integration of experience in community. Truth is not absolute, is apprehended through experiences of beauty, mystery, chaos and paradox and the idea that matter exists in multiple forms. Scientifically and theologically (and pastorally) no one truth exists. The intentional church creates meaning in a post-modern

world where instead of rules, or a right/wrong dichotomy, meaning is found in identity gained through intentional meaning making.

### **Pastoral and Theological Implications from a Focus on Intentionality**

Butler Bass' work, and Ross's theology, suggest two things. First, Pastoral Psychology most effectively finds itself located in the theological quadrant that claims a post-modern and intentional stance in the world. Second, experience is central to the pastoral task, the most effective starting point for theology. Persons in spiritual leadership in the church and those sent from the church for ministry in institutions are able to offer the kind of presence and utilize the theory described in this paper as they are able and open to relinquish exhausted philosophical categories and acknowledge objectivity as an illusion born of the modernist hope in the intellect. This is not to devalue intellect, but to bring intellect to experience; to balance experience with wisdom accrued through the history of spirituality and religion.

In so doing, theology becomes not so much words about God, but words about our experience of God, and what can inform that experience. Students struggle with the notion of presence, of listening to patient's experience, because they are not bringing theological answers. They wonder why they even went to seminary. But the ability to hear pastoral concerns behind theological questions requires a theological education integrated to a high degree. Further, the ability for a chaplain to engage with pastoral concerns in a way that respects the experiential map of a patient points to a powerful use of intellect as well as emotion and experience.

Because she eschews a reductionistic approach, Ross aids this endeavor of re-thinking theology for an intentional and post-modern approach to faith and ministry. Even as she challenges a patriarchal mode of positing God or beliefs, she also resists any attempt to make theology a facile endeavor, such as attempting to reduce truth to utter subjectivity; my truth or

your truth. Subjectivity emerges from the same intellectual approach as the external objective systems of belief that were part of the modernist thought.

Theology that begins with experience and emerges from an intentional and postmodern context has hope for meeting persons for the purpose of healthy pastoral care, no matter which quadrant named above that person may embrace. This theology supports the posture for care named in the theory, a posture of openness; what Ross calls a kenotic stance. This approach to theology gives a profound theological foundation for the chaplain's role. It provides potential in the interaction of chaplain and patient to build a theology for healing. Theology focuses on engagement, not on accuracy to a picture of God.

### **The Power in Kenosis – A Challenge to the Christian Church**

The Kenotic stance reflects a posture for care (and a stance for the church in the world) because for Ross it reflects the ministry of Jesus. (Ross, 1988, p. 19ff) Kenotic means self-emptying on behalf of the other. She contests that the church and church leadership has shifted from a kenotic stance to a way of being in the world that uses position as a means of power as an institution and with individuals. Ross charges that the religion of Christianity that had at its center the example of the Kenotic life lived by Christ has been cheapened and trivialized and destroyed by power.

A Kenotic stance means bracketing fear and learning to live through suffering, including the shattering of illusions of power; learning to risk openness to change rather than avoiding pain or change through grasping at power, including religious agenda. This stance of opening to suffering leads to the potential of transfiguration of one's primordial wounds. From a pastoral frame, that stone which the builders rejected (powerlessness and primordial wounds) has indeed become the cornerstone (Kenotic pastoral care). I am suggesting that a Kenotic stance is at the

heart of pastoral care. Therefore bringing a stance of power, even through a focus on solution, short-circuits a process of care and forgoes the integrative possibilities from a pastoral presence.

Even the invitation to a Kenotic process emerges from a caring stance toward the caregiver. It offers presence to the fear or anxiety that lives behind the need for power, and behind the capitulation (rejection) of this Kenotic stance (stone), i.e. the fear that seeks certainty in the face of ultimate powerlessness. This fear motivates one to grasp at power in a given religious agenda. If one can given attention to one's needs and the fears from those needs, if one can let go of the temptation to grasp at solution, the dynamic can shift away from a theology based on power as well as the fear/anxiety that precedes and/or derives from it.

Stories in scripture affirm this different approach, that God or Jesus, rather than exerting control, over and over go to the heart of pain and suffering with persons. The story of the Syrophenician woman exemplifies this Kenotic approach by Jesus. In the face of this woman's deep need and his experience of her, Jesus capitulates his initial assumption of his ministry, relinquishes power and empties himself to bring presence in the form of hospitality and healing. (NRSV, Mark 7:24-30) This form of presence to the cries of suffering contains hope and the potential for joy that can emerge out of suffering. A kenotic response to God's faithfulness allows one to address the human compunction toward control and use of power.

Ross' central example points to the experience of being woman. The descriptions she uses are also true of persons with mental illness. These persons have been raped intellectually, spiritually, psychologically as well as physically. They have been told their experience and life must be authenticated from the outside according to models, or more aptly named, idols that are set before them. Yet, in order not to assume the same power stance, they must sit in the dark, damaged and wounded and without hope or without comfort or security of illusion of fixing

oneself.<sup>52</sup> This waiting provides the possibility of transfiguration unto their own identity and vocation. (Ross, 1988, p. xix) This foundation of theology invites one in the role of chaplain to inhabit such a space with another.

The Old Testament term ‘anawim’ describes the experience of those with mental illness (or any others) who are despised, rejected, desolate or condemned. Over the centuries, many in religious leadership have posited a particular belief system and called people out to embrace that system of belief, without regard to personal experience. This way of religious leadership demonstrates the misuse of power that creates anawim.

If leadership is to be effective for the ministries of the church, including or especially pastoral care, that leadership must be willing to enter the wounded spaces within themselves. As they move through the complexity of this integrative process, they can engage anawim both within themselves and in the community with transfiguring grace. (Ross, 1988, p. xx) These exhortations to a theological shift are not meant to be condemnation, but a passionate invitation leading to healing and freedom for leadership as well as for congregations of the faithful.

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<sup>52</sup> The encouragement to adopt this posture is not about a person giving up hope of agency in life. If a person is not free to choose to enter such a space, then this stance is not authentic. For instance, a woman who lives in an abusive situation is not required to wait in that particular relationship for some hope of rescue. The stance of waiting would more be applicable if, once out of the abusive experience, this person chose to wait for a time without moving into another relationship; if she took time to live in the wound that took her into the relationship in the first place, finding there a transfiguration to a new place of being that would end up with her choosing a healthy and mutually nurturing relationship.

One chaplain intern was taught in his seminary training that ministry happened through positing a particular image of God. Adherence to that one image and derived belief system was paramount, and all ministry, including pastoral care, meant calling persons to that image and belief system. A good-hearted man, the intern followed this training for years. At one point, five significant deaths including his parents, rejection by a new parish with a history as “clergy-killers”, a subsequent depression and then abandonment by his wife brought this man to a point in which he could no longer live apart from his woundedness. His theological understanding and the image of God insisted on in his training intensified his pain, blaming and judging him for his failure as a divorced person. As he gradually let go of that one image and allowed a community of peers to support him, he found mirrors in the patients he worked with who suffered from mental illness. He realized that he would never want to transgress their fragile spirits by insisting on a particular image of God. Rather, in the way he was supported by his community of peers who were ultimately powerless to effect his healing except by their steadfast presence, he entered his own powerlessness in order to be present to the patients before him.

This story illustrates the potential in living into powerlessness and wounds for possibility of healing. It also reveals the challenge for a shift in understanding of morality. I will say more about the issue of morality, but in this context of theological conclusions, a moral approach is inviting self-restraint in the face of the constant desire to wield power. In a pastoral role, the desire to appear powerful is understandable, and it takes a strong sense of identity and pastoral authority to hold onto a faithful presence in the face of suffering.

One example of this in the mental hospital is seen in the dynamic of patients calling for the chaplain because of their assumption of religious power that can be wielded by the religious figure. Why wouldn't someone want to appear to have such power in the face of such

projections and need by another? Learning to embrace powerlessness and still stay present to the potential wounds and needs for healing that represents that patient's presence in the hospital is a huge challenge.

In another situation in a medical hospital, a woman collapsed over the laundry in the home one day because of an aneurism in the brain. When she arrived at the hospital, her heart had been shocked into life, and she was put on a ventilator, but tests eventually showed that she had no brain function. Her husband and two young sons, nine and six years old, were waiting, a chaplain waiting with them. Into this scenario walked the pastor of this family. The oldest son immediately stood and ran to the pastor, apparently feeling that all would be okay now that he was here. The pastor accompanied the husband and children (and chaplain) to the woman's ICU bedside. He offered a prayer in a powerful voice, insisting on healing. As they walked back to the waiting room he said that he had felt her spirit hovering and he had called it back. Then he left. The chaplain had to consider how to approach this newly complicated situation in which the mother had already died and the waiting time was for such things as decisions about organ donation.

The chaplain suggested to the family, "I don't want to take away the hope you are feeling from your pastor, but..." and at this point that elder son asked the chaplain to wait a minute and he stuck his fingers in his ears and then nodded that the chaplain could go ahead and tell his father what she had been starting to say, concerning the situation of his wife's health. This church pastor complicated the grief of this family in wanting to be seen as powerful, but not having the power to stay present to the actual shock and grief they were experiencing, not being able to enter the powerlessness with them. Kenosis asks the chaplain to enter into such powerlessness.

Integration of experience, including experience of God, opens the way for a kenotic use of power on behalf of another, allows for wisdom in the restraint of power, which creates space for another. In fact, the more power a person is able to wield, the more restraint is incumbent upon that person. The smallest exertion of power can have huge consequences, as in the adage that a butterfly flapping its wings in one place can produce a typhoon on the other side of the world. This way of thinking about power is demonstrated creatively in the fantasy by Ursula LeGuin about "Earthsea." A wise old mage says to a young student, "Do you see, Arren, how an act is not, as young men think, like a rock that one picks up and throws, and it hits or misses, and that's the end of it...When it is thrown, the circuits of the stars respond, and where it strikes or falls the universe is changed." And later in another part of the story, "It is much easier for me to act than to restrain from acting. We will continue to do good and to do evil...But if there were a king over us all again and he sought counsel of a mage, as in the days of old, and I were that mage, I would say to him: My Lord, do nothing because it is righteous or praiseworthy or noble to do so; do nothing because it seems good to do so; do only that which you must do and which you cannot do in any other way." (LeGuin, 1969, p. 71; LeGuin, 1972, p. 136)

Parker Palmer speaks to this same issue of power and control through knowledge. (Palmer, 1993) He extrapolates three purposes for knowledge. The first purpose is acquiring knowledge for the gaining of power to control. An ultimate example of this is the abuse of creation to harness nuclear power as a weapon to subdue. The second purpose for gaining knowledge is that of curiosity. This is about the gaining of information in order to feel more powerful or to have a sense of power over another person because of that information. Again, the motivations are power and control especially over another person or persons or situation. Finally, the third motivation for gaining knowledge is for the purpose of offering compassion.

This third motivation mirrors the kenotic stance of self-restraint; of being willing to stand with another in the midst of a difficult place; of being willing to be emptied of control, agendas and needs to find solutions, in order to be acutely present to suffering and to another person.

Kenotic self-restraint creates density, creates presence in its strongest meaning of *shekeinah*. (Ross, 1988, p. 73) On the other hand, the exercise of power disperses an energy of being, dispelling itself. At a conference for professionals who served those suffering from mental illness, one speaker described a dynamic reminiscent of this contrast of restraint over dispelling of power. She suggested that caregivers working with those suffering from mental illness thought that their role was to shine a light into the darkness living within the person before them. But in her long experience she had come to realize that the task was to stay with a person long enough find chinks in the covering that is mental illness. Noticing those chinks allows one to engage with the light within; to see the person under that covering of illness. This is a powerful way of describing the paradigm shift within the role of the chaplain from a perspective of Pastoral Psychology.

### **A Resource of Tears**

Tears offer a resource and a powerful symbol, serve as both sign and route in this theology inviting a Kenotic way of being. In life, we experience over and over the shattering of different illusions that seemed necessary for living. These illusions are not bad in and of themselves. They are our reality in the way that a delusion is the reality for a person with some form of mental illness. When life experience shatters these illusions, usually it is a cause for grief and sadness, if not fear or suffering. The tears in the wake of the shattered illusion are both actual tears wept and are a state of being that holds the reality of helplessness indicated by tears.

The chaplain needs to resist a cultural tendency to think something is wrong with tears and with weeping; to see tears as something that need to be attended to and stopped and a person “made” to feel “better”. This includes resisting the destructive notion that a person must be ‘strong’ in the face of pain or loss of any kind. Such a notion suggests that “strength” is determined by how stoic one can be in the face of a painful situation and serves the purpose of taking care of those surrounding the person. This way of thinking about tears devalues much of human experience. Similar to the way people view mental illness, tears are seen as a problem that can be dealt with, solved, and left behind. Even persons who work consistently with grief often believe that while grief is a necessary step, it is something unpleasant that needs to be gotten through so a person can go on with life. This view of tears fosters the belief that if something doesn’t feel good, it is bad. It creates a value system that says feeling good and emotional highs are natural and right, and feeling bad or going through loss is unnatural or wrong; is put on a level of disaster. The result yields a way of life focused on the senses, leaving aside soul-level needs and care.

A common scenario for the chaplain sitting with patients suffering from mental illness is the deeply grieving patient who feels the need to resist tears because, “If the staff see me crying they will say in my chart that I am still depressed and they will keep me in here longer.” People are not able to have the tears that will help them move through grief. For some, continuous tears do indicate a depth of depression that could lead to the taking of life. But for many, even the deeply depressed, those tears are necessary to express the suffering that will create space for life and for moving through deep and painful grief.

Focusing on tears does not invite love for misery in any way. Nor does it diminish tragedy. Giving space for tears shifts the view that devalues and refuses to hold all human

experience in esteem, and supports tears as a good part of the human experience. Presence to tears demonstrates hospitality connected to creation, reveals an openness to the heart of creation that the Celtic Tradition so honors. Tears are a sign of what it means to be human. They suggest that tragedy and impossible situations are a part of life. An openness to enter and move through tears and the situations that create tears leads to emotional and spiritual maturity. Tears allow one to progress through loss without becoming pathological or fragmented. The very act of grieving develops strength, provides an internal buffer to protect from the external onslaught of pain and difficulty. Tears are a respectful posture in the face of life experience.

The God of the Hebrew and Christian Scriptures exemplifies this posture. Many of the images in Scripture reveal a God who does not ignore the cries of people, would in no way try to mute those cries. Rather the cries of those who suffer echo the pain of God. These scriptures underlie a theology inviting a strong stance able to embrace all human experience including tears. (Ross, 1987, p, 227) This theological backdrop holds a powerful significance to the theory offered in Chapter Four and to the task of Pastoral Psychology.

### **Sacramental View as Supportive of the Pastoral Role**

Sacrament, in its deepest meaning, is concerned with an inner spiritual experience to which external visible signs point. A sacramental perspective is central to a theology that invites experience of God over positing God. Bringing a sacramental view to the pastoral role underscores the need to respect experience as a theological starting point. It invites meaning making from all of life experience, having eyes to see the Other in all situations. Most Christian denominations affirm two sacraments of Baptism and Eucharist. Five other actions specific to the ministry of the church are also seen either as sacraments, or as sacramental acts, marriage, confession, anointing, ordination, and confirmation.

These sacraments or sacramental acts derive from central activities connected with our humanity, activities that also operate at a spiritual level. For example, Baptism speaks of inclusion and belonging, the essential oneness of all creation. Eucharist means thanksgiving for feeding that expands to all kinds of nurture. Marriage blesses relationships and signifies intimate connections with others; Confession is telling the truth about who we are, coming to see ourselves and sometimes calling ourselves back from places we have been. Each of these sacraments has a breadth of meaning. Each deepens the fullness of human experience and points to the spiritual. These outward and visible signs of deeper meaning, these metaphors for human and spiritual experience emerge from a Kenotic theology. They invite viewing all of life from a sacramental perspective, the Creation being the primordial sacrament, the outward and visible sign of Something More, or a Gracious Source inherent in all that is. This sacramental focus on creation, central to Celtic Theology, offers a theology profoundly based on hospitality, on providing a space and a welcoming for persons, allowing them to feel care and belonging, to know the dignity of being human.

Limiting the meaning of sacrament to the two (or seven) specific religious actions means that much of the richness of meaning and theology is reduced to the legacy of a dualistic and inherently judgmental approach to theology and derived religious experience. A strong divide is set up between what is sacred and what is secular, blinding those serving as chaplain to the spiritual in the midst of ordinary life and the lives of those in their pastoral care.

P is a nurse who struggled with the fact that she heard angry adolescents say to her that they didn't believe in God, knowing how strongly she felt about God. P mirrored their anger, telling them it was wrong to say such things. She finally spoke with a chaplain, trying to get validation for her strong dualistic viewpoint. P said that she was miserable because she wanted

to serve God. She didn't want to go to divinity school, but was frustrated that she couldn't make people have her values about God where she was. The only way P could understand service, given the teaching she had received, was to have it be about specific sacred things, apart from any so-called secular endeavor (as she viewed her nursing role).

P's experience is a clear example of dualism from a sacred/secular split fostered by the lack of a sacramental viewpoint. (Miner, 1990) This sacramental vision gives space to make theological meaning as a chaplain that is enriching of soul and spirit. It serves as another part of the theological foundation that can support the chaplain in ministry with those suffering from mental illness.

### **A Stance of Solitude**

Emerging from a sacramental view and linked to the Kenotic expression of theology is a resulting stance that Ross refers to as Solitude. (Ross, 1988, p. 90ff) Solitude in this vernacular does not refer to being alone, but to a posture of openness. Solitude as a stance is another conclusion drawn from the theory in Chapter Four. Entering into solitude means giving up control, waiting in an unknown darkness. Solitude describes the posture of a chaplain sitting with another suffering in the darkness of mental illness. Solitude raises the awareness that if one grasps suffering to try to turn it to profit, even if that profit is in trying to make another feel better in the moment in order to address one's own anxiety, one has moved from a kenotic presence to technique and escape.

The theory in Chapter Four stated that the chaplain occupies the only role not focused on 'making' people feel better in the moment. Rather she helps another connect to his experience and learn to trust his own resources and inner wisdom, as she listens resources and wisdom into being. If we take on a burden of control and let go of solitude, a person is further isolated.

Approaching another in a stance of solitude, of open readiness, without trying to control, offers that other the possibility to experience community, no matter how small, in the midst of great suffering.

R is a patient in her eighties in the psychiatric hospital, relatively new in the US. She was losing her hearing and other forms of her independence. In response, she sunk deeply into depression. She struggled living from day to day before and after she came to the hospital. R was marginally participating in a spirituality group one day, largely because her main positive relationship had been with the chaplain who sat with her from time to time. The group was offered three passages from the psalms. Persons were invited to say which best described their current spiritual life. The passages were: Ps.27:1, The Lord is my light and my salvation; whom then shall I fear? Ps. 30:6, Weeping may spend the night, but joy comes in the morning; Ps. 22:1, My God, my God, why have you forsaken me?. (Book of Common Prayer, 1979)

Patients and staff alike participated, most of them choosing the first option and telling about their faith. A few took the second option and talked about a difficult time they remembered and how they emerged from that time. R sat through most of this, seemingly only hearing parts. Finally when she was invited to respond she spoke loudly. She lamented that the third one was how she felt, that her prayers didn't get beyond the ceiling. The people in the group tried to reassure her that God was present with her and could hear her prayers. This was not at all reassuring to R.

The next day the chaplain returned to that ward. R asked her where the scripture was in the Bible. The chaplain showed her both selections...from the psalms and from Jesus' cry on the cross. She was greatly comforted knowing she had community who understood her experience, knew how she felt. Efforts to control her experience, to make her "feel better" were more

isolating. Being joined in that place of suffering, by the chaplain and even or especially by people of history in the scriptures, allowed it to become transfigured and a place of community. Beginning with experience and bringing a kenotic wiliness of solitude is vital for the stance of the chaplain. This theological grounding allows for the chaplain to be in a religious role and also present to a variety of human spiritual needs.

One theological challenge to a Kenotic stance of solitude that Ross names and laments comes from the historical theory of the Substitutionary Atonement, a legacy of the Greek inheritance in Western Christianity. This legacy feeds the need to deny wounds and to fix the self up to be acceptable to a God who is posited as demanding of perfection. The result is a cosmetic process, a counterfeit offering of the self. While it speaks to a strong understanding of one view of grace, it offers little room for actually experiencing transforming grace. In the same way, the contrast of Ezra and Isaiah in Chapter Three gives an example of the difference between that which emerges from a posited God and religious system (Ezra) and emerges from grace unto transformation (Isaiah). In this theological foundation for pastoral care, the stance of solitude allows the chaplain to become aware of her own motivations emerging from unacknowledged wounds and transitioning from resistance resulting in control to entering these wounds for the possibility of coming into a kenotic stance.

K was a young woman who wanted to work with struggling adolescents. Having come from a broken home and suffering through the foster system, she wanted to help others in similar situations. She hadn't counted on the adolescents in the hospital seeing her as just another adult. She wanted them to know her history, convinced they would come to trust her. Underlying this desire, she also wanted visibility for the ongoing painful wounds from her young experience, wanted the young people to know how hard it had been for her. K had to learn of this need and

then learn how to stand present to her wounds and ask for appropriate support so that she didn't look for care from the adolescents she wanted to serve, didn't try to take care of her own wounds through them.

All of ourselves, our mistakes, wounds, and needs, along with the more positive aspects are essential in the service of another human being. If one can bring all of this to bear, if one is able to enter the willing solitude that is Kenosis, then that person's being sounds a clear note that can be heard far more than any words that might be spoken. This is a way of soul-making, a process as much as a foundation of theology for the offering of pastoral care.

### **Three More Theological Concerns Drawn from the Espoused Theory**

In addition to this specific theological stance from Ross, three other theological concerns are important as derived from the theory offered in Chapter Four. Ulanov, Frankl and Ross again are central resources in articulating these concerns that are concluded from the theory espoused.

#### **Concern #1: Morality**

When writers of the U. S. Constitution created that document, they assumed the church would provide moral glue that would hold society together. They further assumed that the morality provided would allow for future changes to the good to this elastic document, changes that would be needed over the years. (Fairfield, 1983) Since that time, many churches and religious groups have insisted upon a morality highly privatized to personal behavior, offering legalistic rules, especially regarding behaviors in matters of sexuality, that they assume should be applied to all persons.

One result in this development of morality is that many larger issues, such as war, hunger, economic inequities, and the application technology amassed by later generations, now exist in a context of little moral guidance. Large corporations have minimal sense of

responsibility for care of the planet or other humanitarian concerns beyond assuring shareholders of profit. Another result is that many in the role of pastor believe that they are being asked or required to hold up a norm or set of 'gate rules' for behavior. This privatized and rule-bound approach to morality has often wreaked havoc on the fragile psyches of those with mental illness. A different way of defining morality must be one conclusion drawn for the theory espoused in Chapter Four.

J is a geriatric patient who likes to attend church. His face is furrowed in a constant frown. When J doesn't hear a message of judgment and shame preached to him, he supplies it on his own, calling out at the end of any given sermon for a meaning of the text of the day that is highly judgmental, that spews judgment over himself and all around him. F is a patient who returns to the hospital often, living in a constant state of anxiety for all the ways she is displeasing God in her thoughts and actions, no matter what she does. A is a patient who, every time he leaves my office, requests that I clean anything he might have touched as he had not been pure that day and so he defiled my office with his contact. N is a patient who repeatedly is sure she has committed the unforgivable sin and lives with constant fear. Each of these patients represent a host of others who live with the same struggling psyches and souls, resulting from shaming messages heard from those preaching the brand of privatized behavior-focused morality described along with threats of shame and punishment.

For these folk with mental illness (and the rest of us for that matter), ethics and morality as an assumed part of the religious endeavor need to be reframed in ways that allow for responsible moral development. This reframing of morality is not a new idea. Many churches embrace underlying theologies that challenge them to turn to the world in service. These churches see ethical mandates in the need for environmental care and humanitarian need as well

as for addressing the public policy that guides decisions related to the same. How are churches helping individuals to develop and mature morally apart from a privatized agenda for behavior? This question is central for those offering care for persons with mental illness. As hinted in Chapter Four, Frankl, Ulanov, and Maggie Ross are inviting a response to this question that offers a way of moral development quite different from assumed behavioral norms often projected onto clergy.

Ulanov addresses the issue of morality in no uncertain terms in many of her writings. She invites a courageous endeavor of inner exploration, risky though it may be, as the route to moral development. (Ulanov, 2003, p. 116) She suggests that we have been taught throughout the ages in a variety of religious settings, taught by what is thought to be a long and honorable tradition, that living a moral life means that we deny the images and feelings that live within us. But what this potentially produces is something more akin to moral torture. This form of denial is more likely to create the opposite, moral infants who are never able to grow into responsible moral and spiritual persons because the process that would allow such growth is not made available. Rather we are trapped in a need for certainty that limits moral and spiritual development and creates fragmentation. Or we turn from any sense of morality whatsoever and allow full sway to our desires, regardless of how they might affect another or ourselves.

The very Christian voice that has warned of moral danger in listening to and following desires deep within may well have resulted in the current addictive society. When one learns to hear the desire of the heart, to listen to the soul's message living deep within, the moral call may be to a hugely different life than the distracted life we might be living. In the wake of Sunday School answers that seek to explain away all mystery, this moral way invites attention to the longing for truth and the deeper fuller life possible through attention to self.

Reducing these meaningful religious and spiritual invitations to specific rules of behavior actually contributes to the plight of those with mental illness. The way in which the third commandment of taking God's name in vain has become trivialized exemplifies this process of reductionism. In most religious contexts, this commandment has come to refer to speaking the names of "God" or "Jesus" in times of intensity of expression. People are taught that using these names in any way less than reverent is breaking the third Commandment. Yet this rule, this ethical stricture belies a much more damaging meaning for this Commandment. Many religious leaders and people in their communities, often without awareness of their own motivations, speak to another in authoritative language, in God's name in fact. These leaders insist that they have the perspective of God, insist that God wants someone to do this or that, or that God is going to do this or that to someone. This way of using God's name has potential to be much more dangerous and damaging. It expresses an immoral lack of restraint and use of power, and is the opposite of a developed moral approach to this commandment.

Maggie Ross makes this same lament and looks at the havoc that such an approach has wrought in church and culture alike. (Ross, 1988, p. 146) She, too, sees that a focus on a particular image of God and having ethics and morality as an externally imposed set of strictures lives in the very air we breathe in this culture. This set of external rules has created a system of judgment in which persons respond in one of three ways. Either they abide by imposed rules with no thought or sense of personal responsibility; or they choose not to abide and live with guilt or with an identity as a cheater; or the rules are rejected out of hand with no reflective process of decision-making set in place.

One needs a strong and courageous identity to let go of the cultural psyche in order to engage with Mystery and develop as a moral being through the integration of experience. One

needs a strong pastoral authority to sit with the fragile psyches and souls of persons suffering with mental illness in pastoral need, creating a space for a moment of integrative healing. Even in a context that acknowledges the metaphysical/supernatural realm, a moral way of being that sees prayer as attending to the depths of longing offers a way to live the metaphysics that is God, a way to experience beliefs rather than the detrimental stance of trying to posit them.

The other dynamic that intersects with this external imposition of morality is the focus on sexuality, so much so that for some persons, the word moral equals right rules concerning sex. Because of this focus, many of the most dehumanizing of ways of life: economic disparity, racial discrimination or environmental abuse, slip through any moral monitoring system without so much as a blip on the screen. If integration of life experience is the central task of spirituality, then a more mature and owned morality of self-restraint in the area of sexuality is possible.

Karen Armstrong, who has studied the texts of all religions, invites a similar understanding of morality. (Armstrong, 2005) She names the Golden Rule as a tenet embraced in some fashion by all faiths. This tenet points to Self-restraint as a central stance that includes respect for all of creation. In the Christian Scriptures, we are invited to respond to others from the perspective of what we would want for ourselves. Interestingly enough, some faiths have a version of the Golden Rule that is even more focused on restraint; of not doing to another what you would not want done to yourself. Many discussions have ensued over which is a more difficult application, yet in all of the ways that it is expressed, the Golden Rule gives an example of a growing morality of self-restraint.

Perhaps Frankl, from his noetic focus on meaning making, has the clearest description of morality and moral development, especially for the purposes of effective and mature pastoral ministry. In order to address what he refers to as an existential vacuum, Frankl describes a way

of living he calls Responsibleness. (Frankl, 1988) He chooses this term with great intention, contrasting it with responsibility. The latter is an assumed duty or expectation from an external entity, whether family, country or religion, which represents what someone may feel she 'should' do. Frankl believes this form of externally motivated responsibility detrimental. It places expectations on persons that may well not correspond with the noetic need within them.

Gaining awareness and meaning from one's own framework, one's personal "ought", involves listening for internal clues from the heart and soul as they blend with external needs in the world. Seeking and responding to this personal "ought" captures the process Frankl calls Responsibleness. For Frankl, it is incumbent upon humans, not simply as an external moral responsibility, but as a noetic need, to live in such a way as to discern and respond to meaning in life. He does not suggest an external power or God gives meaning for life. Nor does he posit that a person simply makes up the meaning for her or his life. He intentionally does not explain this element specifically, not wanting to take away the dynamic of interaction with life and meaning. Responsibleness means facing into our existential vacuum and from that honest look into a lack of meaning from external sources, finding meaning and our internal wisdom for living well and morally in this world. Without Responsibleness, humans are not directed by their inner instincts of what they must do, not guided by their inner wisdom or values, rather conform to what they believe some other wishes for them to do. This is the danger of the deontological approach to ethics, especially when a given pastoral leader seeking power interprets the "rule".

Frankl is convinced of the potential for personal Responsibleness and moral growth, no matter what the given background of a person, even if that person is challenged in areas of environment or IQ, including those with mental illness. This respect for the uniqueness of all persons and for the possibility of personal growth offers another voice inviting the chaplain to

bring an acutely person-centered presence, to trust the wisdom in each person for the living of her or his life. Chaplains, then, must look into the well of existential crisis in our own lives; must be involved in the moral task of meaning making in the face of apparent meaninglessness.

Frankl's invitation to morality as Responsibleness, as the process of discerning the dialogue between our unique identity and that which life presents to us, connects to a process offered by Ross who has similar concerns about morality. In considering how to be about discernment unto moral development, she has utilized the three monastic councils of Poverty, Chastity and Obedience. She has shifted them from an external and legalistic understanding of morality and reframed them for a moral process of discernment. She has seen the devastation wrought when these councils have been understood in a legalistic sense: the first council limited to financial wealth; the second council limited to genital intactness; and the third council focused on an externally devised or posited will of God in place of a creative interaction between one's inner wisdom and the world beyond.

Ross has taken these three councils and reframed them as three questions of discernment. (Ross, 1988 p. 145ff) The first question, based on poverty, is "Where do I hurt?" It is a question of self-care inviting reflection on spiritual poverty. It asks me to look to the primordial wounds of my life, for they often hold the key to the need for healing and so for Spirit. Referring back to the description of mental illness in Chapter Three, just as a physical fever is an attempt by the body at curing a virus; just as mental illness is a metaphorical fever of the psyche; in the same way our primordial wounds are metaphorical fevers that hold the possibility of care for the soul. This question about where I hurt is not about fixing a situation or asking how one might feel better in the moment. This question invites self-awareness at a profound level of being, and attention to and connection with primordial wounds. Avoiding these wounds opens the door to

living with a desire to control another. Acknowledging the wounds and the needs derived from them allows awareness and integration unto potential for healthy and mature spiritual service.

The second question, based on chastity, is “What do I really want?” This question is one of self-confrontation. It asks me to separate out external expectations, those things that others want for or from me, in order to connect with the deep desire of my heart. (NRSV, Ps. 37:4) It asks me to consider what deep desire is given to me for my delight. This focus of chastity allows for a purity of being in the world. It reflects the deepest layer of the many questions Jesus asks throughout the gospels...”What are you looking for?” “What do you want me to do for you?” This question holds up a mirror and invites me to behold who I am becoming, and to ask if this reflects the depth of my heart and soul in the world. This question challenges the notion of an external “will of God”, that I have to figure out (or that another would figure out for me) and wonder if I have missed. From the perspective of the chaplain, self-confrontation is very different from confronting another person with my agenda for that person. It involves a far more responsible position of listening to my own depths so that I am able to be present with another at great depth, and as much as humanly possible, without an agenda beyond an intention for care; without the need to control, find solutions or to “make” feel better.

The third question, emerging from Obedience, is a question of self forgetfulness, “What am I willing to pay?” If the cost, given my particular gifts and limitations is too high, then I won’t be able to be self-forgetful and true to the task before me, but will remain self-focused and either highly anxious and/or eventually become bitter and resentful. This question allows me to consider what I can offer with an open hand and open heart. It invites me to look at my gifts and limitations without flinching at either, and in light of those, to consider the choices that lay before me. The question may eventually lead to greater and deeper offerings, but it helps me

discern what I can and can't offer in the moment. These three questions, respectful and honoring of experience, are resources for an approach to morality connected to Frankl's Responsibleness.

When such processes are denied, when those "gate rules" become the moral basis for inclusion in a given religious community, no one is invited to a personal responsibleness that lends vitality and depth to life. Rather the soul is negated in favor of dualistic rules that don't allow for thoughtful continuing moral development. As such, they diminish both the gift of religion and the task of moral responsibility. Instead they create moral infants, responding to guilt and draining away the experience of a life worth living. The chaplain serving those with mental illness does well to bracket any such gate rules and to stay present to the noetic needs of a given patient, to hear the cries of the soul, even when expressed through behaviors that may seem offensive. In this way can a chaplain potentially be of help for someone in a process of moral discernment; help that person to consider what might be immediate ego wishes and what might be a depth of noetic meaning.

Ethics and morality are essential for the continuing care of those with mental illness in our society and for any continuing development of our culture. Yet as long as ethical or moral development is defined by adherence to external rules from a particular system, be it religious or not, then continued moral growth is limited at best. A spiritual morality attends to the inner wisdom of each person and helps them consider how that wisdom interacts with the world and how best to respond to a moral imperative. Far from relinquishing any moral way of living in the world, this understanding reframes morality to a mature response from one's entire being and allows for a mutuality respectful of the dignity of every human being.

## **Concern #2: Salvation**

Many voices from the Christian sector are challenging an understanding of individual salvation by a particular image of God that involves intellectual assent to a system of belief, and adherence to a specific set of behavioral norms. Up to this point, I have mostly hinted at the issues of powerlessness and need driving the strong human desire for inclusion and reunion motivating a religious certainty that is a pre-determined individual salvation. In the Early Church, when hammering out Christian Theology, the fiercest infighting focused on theories of the atonement. Other discussions, including those on the nature of Christ, were directly linked to atonement and salvation. The ongoing focus of theologians in the church from Aquinas to William of Ockham to Luther and Calvin, all looked at Salvation; what it was and how it was received and who might think to hope for it and by what means. The focus of theology that we call Soteriology, the study or history of Salvation, infuses and inhabits all other theological endeavors, whether directly or as a sleeper issue.

Although often intended as pastoral reassurance, in much of Christian religion, salvation is used in a way that does not sustain quality of life. Theology has done a great disservice in the present and past centuries, pointing to a literal (geographical) hell and heaven when so many live with gap and the isolation the gap experience brings. To further the isolation and immediate experience of separation and hell, a formula of belief and a mode of behavior for some distant day of 'salvation' is proffered. Contrasting with this meaning of salvation lies the powerful possibility named in Chapter Four; the one-on-one experience of connecting with a person in their isolation and separation and allowing a shift from gap to connection and space. In this meaning of salvation one can hear the echo of meaning in the words, "the kingdom of God has come to you" (NRSV, Luke, 11:20) and "The Kingdom of God is among (or within) you" (NRSV, Luke 17:21).

Oliver Wendell Holmes said, “I don’t give a fig for the simplicity on this side of complexity, but I would give my life for the simplicity on the other side of complexity.” (Holmes, n.d.). He was not speaking out of a religious or spiritual context. But his words support this meaning of salvation that touches into the immediate. The simplicity on this side of complexity suggests that salvation relies on the described adherence to a particular formula of belief for inclusion to a predetermined Heaven.

I have attended a myriad of funerals and memorial services given for work colleagues. In churches across the central region of my state, with very few exceptions, the preachers held up this intellectual assent to a belief system as the way of inclusion and used the opportunity in the wake of loss of life to warn all persons present of their danger if they did not adhere to this one particular belief system. These sermons were not life-giving or spirit-sustaining. They espoused fear-driven compliance. Through this view of salvation, a life-sustaining faith and the possibility of spiritual freedom are relinquished. The wondrous noetic potential found in the wake of the powerful human hope and need for ultimate inclusion and belonging past the veil of this life, as well as the possibility of reuniting with those we have lost and long to see again (who took some part of ourselves with them), is forfeit through such preaching.

This way of salvation limits and diminishes life, prevents enjoyment of the creation given into our hands to enjoy. It stands with the some of the most repressive of religious expectations draining and killing the spirit. For it never allows persons to face into the fears and uncertainties that emerge from our humanity, never allows a fullness of engagement with our depths, never allows us to learn how to live lives of faith rather than lives of fear seeking safety. In this unfortunate framework, rather than offering a powerful model and invitation of freedom and possibility, Jesus is relegated to serving as a victim, a model drawn upon over and over to justify

religious laws and agendas, including such destructive exhortations as keeping persons in abusive relationships.

Even for the Christian tradition, a way of salvation that is faithful to the model of Jesus is one that faces into the depths of agony and finds there the means to life. This reframing creates an understanding of salvation that can be a foundation for working with spiritual needs. This work can result in a highly integrated experience of trust and inclusion. This salvation is a movement into ever-widening perspective and choice; a movement into freedom. It is a movement toward engagement; an immediate and incarnational process that ultimately holds the potential for the exploration of and engagement with Mystery. It continually invites a spiritual way of integration of experience. It is movement through enough shattered illusion and darkness to trust the process that is spirituality, and to find the hope and possibility of a deep wellspring of joy. (Ross, 1988, p. 291) This understanding of Salvation serves as a model and foundation for those serving persons suffering from mental illness in the role of chaplain.

### **Concern #3: Scripture**

The use of scripture in pastoral care, as in the rest of ministry, has many different approaches; and is motivated by differing theology underlying these approaches.<sup>53</sup> The

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<sup>53</sup> In this section on Scripture, I am largely alluding to the use of Judeo-Christian Scripture, both in the way scripture has been misused, and in suggesting ways for chaplain's to use the tool of scripture. As the US becomes increasingly multi-cultural, the number of Muslim Buddhist and Hindu patients will increase. Growing knowledge of the scriptures of these faiths can be helpful, and the ability to draw from other sources that can function in the way of meaning-making and experiential connection as offered in this section may also be important. These other resources may include such things as passages from Shakespeare, Walt Whitman or Mary Oliver.

conclusions drawn for the role of chaplain as it connects to the use of scripture is two-fold. The first conclusion is that, congruent to the theory offered as well as the theological assumptions made, experience of the patient must serve as the beginning point for the use of scripture and therefore holds the locus of authority for a given passage of scripture.

The chaplain does not offer a scriptural answer for any given pastoral issue in using scripture. Rather, the experience of the patient as it connects with the wider story of the people of God creates the potential for a congruent and helpful use of scripture. It also points to the locus of scriptural authority in this congruence of experience, and not in a particular *apriori* understanding of meaning, or as having deontological rules for the living of life. For the chaplain, use of scripture in pastoral care for those with mental illness happens through connecting the stories of the people before the chaplain with the stories of the people of God within the scriptures. This is done only if and when that patient clearly sees scripture as a resource and is capable of making the connection of meaning between that patient's story and a given scripture story. To become entwined in a battle of logic about a text of scripture, or to use scripture in any way to admonish or confront a patient is most unhelpful, further isolating that patient by buying into a rational stance in a non-rational experience.

A, a long-term patient at the hospital, used the scripture in a highly legalistic way. He especially focused on the passage in the Hebrew Scripture discussing the Nazarite vow about not putting razor to head. So A refused to have his hair cut. His naturally kinky hair eventually stood out almost a half foot from his head. A was a young man with a sweet disposition, but his hair made his appearance one that initially created anxiety for those who didn't know A. At one point, the hospital staff began working toward A's discharge and took him to visit group homes.

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After a few visits, they came to me to say that these homes were loathe to take A given his appearance with his large head of hair. They wondered if I might help him understand his misinterpretation of the scripture.

In approaching A, I was aware of how isolating and unhelpful logic would be in the form of a battle of quotes. A knew his bible well, as did many of the patients in the hospital, and could stand his ground with any rational argument, quote for quote. Two interventions helped. One was asking about A's experience that caused him to adopt the Nazirite vow. Over time he was able to begin to hint at his guilt for having abused his younger sister. In the face of this guilt, A felt the need for an extreme form of penance that included this Nazirite vow. The second intervention, honoring his need for maintaining the vow as he understood it from scripture, was to see A apart from only his illness and to name the problem of A's hair directly and ask for help and ideas from A. Eventually, having his sense of guilt recognized and his humanity respected, he agreed to put his hair in small corn rows against his head which produced the same effect as a hair cut, but allowed him to maintain the sense of penance that he was not ready to abandon. This recognition of A's own interpretation and use of scripture allowed us to honor his spiritual need in a way that also addressed the issues preventing him from release.

The second conclusion concerning the use of scripture in the pastoral role looks at the pastoral use of scripture. While this conclusion mirrors the first as an issue focused on the meaning of authority and the use of scripture congruent with the theory and theology offered, the practical application quite is different. F was a patient stuck in fear, although this fear was caused by a delusional reality in which F felt powerless over an unknown and evil intruder lurking in her home. She was also afraid about her stay in the hospital and her diagnosis of a mental illness. For F, the scripture and her faith were both strong resources and it was clear that

for her, drawing on that resource could be meaningful and powerful. After the chaplain listened and validated F's felt experience for a time, F asked for a prayer. Included in the prayer by this chaplain were the words from one of Paul's letters: "God hath not given us the spirit of fear; but of power and of love and of a sound mind" (KJV, 2Tim 1:7). F's immediate response to this scripture in prayer, her affirmative "Yes, Lord," revealed the way in which this scripture offered power for her to have as a resource in the midst of her gap experience of great fear.

CPE interns regularly encounter patients wanting to quote, dispute, or in some other way bring scripture into their pastoral encounters. My hope is that they learn two things. First, I hope they learn they cannot win in any battle of quotes or meaning. For the patients with mental illness, as well as for many other religious persons who accord the Hebrew and Christian scriptures a high status of authority, this is similar to arguing over a delusion central to that patient's reality. It is a fruitless and potentially harmful battle. Second, it is my hope that students learn to listen to scriptures quoted with the same ear for pastoral concerns that often live in delusions and in other communications. Often strong felt concerns or pastoral needs are enclosed in the meaning a patient attributes to a given passage of scripture.

### **Formation for the Role of Chaplain for the Mentally III**

Given the theory espoused in Chapter Four, how does one prepare for this role of chaplain? How does one clarify a pastoral identity and the internal authority to live into that pastoral role, especially in working with persons who have a mental illness? The theory (and theology) in this dissertation, as it gives a focus for ministry, also reveals the means for formation: begin with experience; offer opportunity for reflection and integration of theory and theology; allow space for the soul/psyche interchange; stand in another's gaps of isolation, all these ways of ministry also become ways of formation. To adopt any other manner than

modeling the ministry itself flies in the face of all the resources I have suggested thus far. Without this approach to formation, students may well miss the deeply spiritual potential and nature of the role and take on the very medical and religious models that can miss the human spirit and the depth of spiritual and religious need in the person before them as well as within themselves.

I watch those coming for the CPE formation process wrestle with highly developed theological understandings and wonder how to connect them with the person before them suffering from delusions and depression. I see students with highly formed theories of community come face to face with the reality of how little community or connection is experienced by persons with mental illness. And then I see the students recognize the way in which their own theory of community has served as a way of isolation. I see students who have grown up with one resource for all of ministry of an agenda for salvation, and then come to find that the complexity of ministry means that they live in great defensiveness. They struggle with letting go of that one strong agenda in order to learn other skills to help them stand with those in need and bring a presence that allows Presence.

Four main questions of integration present themselves to those training for this role of chaplain, especially in the context of ministry with persons suffering from mental illness. First, how one integrates religious history, including the theological and religious understanding of the role of chaplain. Second, how one integrates theory to help with a foundation for ministry. Third, how one integrates personal history including the way certain aspects of pastoral connections can be influenced by that history. Fourth, how one lives into the process of meaning making and understanding the noetic potential for one's own life experience, a process the chaplain can then attend to in others. Experience stands behind each of the four areas as central

to integrated learning. Concepts heard and understood at the level of intellect do not take root until situations arise allowing them to be lived.

L was a seminarian who took an intensive summer unit of CPE. She was a bright young woman and a quick learner about process and dynamics. One of those dynamics I offered asked the interns to notice when significant energy appeared in a given relationship, strong energy *either positive or negative*. This energy could well mean that some part of you lived in that other person, a part you didn't like or some hidden part, some inner pearl you hadn't been able to acknowledge.

Two-thirds of the way through the unit, many people outside of the hospital came to L with pastoral needs, some for whom she had a very high regard. L was amazed. One support person suggested that these people had held such high regard for her because within her were the same positive aspects she was seeing in them, aspects that were becoming manifest. She was profoundly impacted by this possibility. The earlier theoretical statement about this very dynamic had no immediate experience to connect to, and thus had no meaning for L. But in the wake of her shift of role with several of these people who she previously had on a pedestal, when she heard the theory again, it held a profound frame of understanding for her experiential reality.

This example is a simple one that reveals something so constant and normal that one hardly ever notices it. A person only takes in, by way of integration, that which connects to a lived experience. Communication of a theoretical nature does not integrate into a person in such a way that it is understood and available for practical use until and unless it is connected to experience. An experiential learning process is crucial for learning to offer ministry to those with mental illness.

## **Integration of Religious History**

The stance of a listening presence challenges interns who see themselves inhabiting a religious role with preconceived notions of bringing God to others. R was a second year seminarian who had distinguished herself as a student at her seminary. About halfway through an initial didactic on the central elements of pastoral care, she began to shift and move around and finally, unable to contain herself, she blurted out, “Do you mean that we are not supposed to tell these people about God at all?”

R struggled mightily with the idea of presence and hospitality as central in living into the role of chaplain. I listened to her struggles, offering space and hospitality as she explored her role and her resistance to the role as presented in the didactic. Then she began her ministry, working with patients and especially with women suffering from addiction and the social and environmental challenges that accompany that disease. She found that the religious understanding she initially thought she would bring to patients, even the picture of a loving God, sounded hollow in the face of the continuous onslaught of painful experience in the stories of these women. She began to see one element that was a constant in their life. Everyone, including their churches, had “answers” for these women, had rules for how they needed to behave and what they needed to do. If she brought her religious agenda, even to offer comfort, she simply joined that long list.

R, by the end of her internship, named three things central to her learning. First, she recognized the power and integrity of her role when she brought an authentic presence, offering hospitality out of her own being, space for the stories of these women, and validation for their difficult life experiences. Second, she developed a theology of presence that she could articulate powerfully from her strong base of academic intellect and that more and more took shape as she

re-entered the arena of her seminary community.<sup>54</sup> Finally, she acknowledged the importance of a similar stance of listening with the acceptance, validation, and positive regard she experienced from her supervisor as she wrestled with this very different notion of ministry than she had been taught in her religious history. As she acknowledged these three things, she also saw how she could utilize the theory offered in the unit to hear the spiritual and/or religious possibilities of resources that could connect with the experiences of the women she encountered.

### **Integration of Life History**

Again and again I witness students who have never or rarely been exposed to people in a crisis of the human condition. These students carry into every relationship they encounter, painful life histories, or at least pockets of unintegrated historical experience that affect them but of which they are unaware.

J grew up in a family with much chaos. His early difficult years deepened into acute crisis when he was a teenager. Both of his parents abandoned him and he had to survive on his own. Now in his forties, he came to CPE feeling like a fairly self-aware and self-sufficient person. Clearly he had done significant work toward healing a difficult history. Often he was able to hear patients talk about many highly difficult areas of life experience and stay present, reflecting feelings. Yet he had an edge with patients that tended to seek information over assessment for needs. As he presented patient encounters to his peer group, a pattern began to emerge. Every time a patient spoke of painful experiences with parents, J would shift, would

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<sup>54</sup> R eventually combined her experience, her theological acumen and her creativity and in Holy Week set up in her seminary chapel a Stations of the Cross. For each station, she had painted a woman or women in a kind of travail connected to Jesus' passion at that station, and connected scripture and experience powerfully to tell the stories of these women.

respond with globalizing words – “everyone has that...” or “we all know about...” – words that minimized any suffering a patient might be trying to articulate. He was astounded to see this in his materials.

As he eventually opened himself to this dynamic and renewed integrative work on his painful history, his manner of being shifted. Patients and peers responded with openness and vulnerability to his presence and care. He found a wider space for making assessments of difficulties and conflicts both in contexts of ministry and in peer group experience. At the end of the unit, this world-savvy man admitted that he had not expected to learn anything from the process of CPE, had seen it as yet another required hoop from his seminary and judicatory. In a confessional manner, he acknowledged the value it had been for him, especially in two areas. First, he saw a need to open back up the book of his history for continued healing so that he might be able to offer more healthy pastoral care. He did not want to limit anyone with issues similar to his own that he was not willing to explore. Second, he learned a more hospitable stance to conflict, hearing the possible need it indicated more than immediately controlling or managing conflict in a way that sent it underground.

N’s experience offers another example of the need to integrate history in order to be present to others. She came into the unit eager to learn with little understanding of the CPE process. In the first verbatim she presented to the group, she described a visit with a man who, throughout the conversation, spoke about being angry with his mother for putting him in the hospital. In each response to his seven or eight statements of growing frustration with his mother, N focused on some tangential point of his statement, never responding to or noticing aloud or validating his feelings about his mother. In her analysis about the patient she said, “Although he never said, the patient may have had some anger with his mother.”

During the discussion of the verbatim, I noted this disparity between her analysis comment and the actual conversation. N responded in a tone of reasonableness, but without any clarity, rambling in a meaningless fashion. Finally a peer asked N if she had any conflict with her own mother's choices for her life. N noted that the coming Sunday was Father's Day and her mother would expect her to send her stepfather a card. Then she gained in passion and clarity as she spoke of her mother's remarriage and her sexual molestation by her stepfather. Her passion was even greater as she recounted her mother's unwillingness to believe her story. Now, twenty-eight years later, she found herself sitting in a group process, staring into the well of her anger that she had resisted for all that time. N faced into her suffering about her mother's insistence that she continue to relate to and respect her stepfather. She saw clearly that, because of her resistance, she had not been able to validate or even hear the patient's frustration with his mother.

These are two rather dramatic examples of this process of formation by way of awareness of how history affects pastoral care. Other examples reveal some of the less dramatic but no less important effects of our history as it connects to and impacts pastoral care. E was visiting an older woman in the hospital who complained often that her family didn't come to see her and grieved this lack of support. E tried to convince the woman that her family did care and probably did come to see her. When we processed the verbatim, E could see that she had tried to change the woman's reality. She realized her own grandmother's complaints affected her. This grandmother lived in a rehab center and E's mother had tried to get by for a few hours each day. When she couldn't, the grandmother complained harshly that her family didn't care. E's anxiety on behalf of her mother appeared in this encounter, even though this patient's family actually did not visit or support her.

S visited a borderline patient who complained to her about the staff. S became angry and fearful and quickly shifted conversation, leaving the ward quickly. In presenting the verbatim to the group, S realized that the situation mimicked a dynamic in her family. She often found herself stuck between her parents and her younger sister who had Borderline Personality Disorder. She responded by running away emotionally in her home and on the ward had left the situation physically.

Sometimes life history emerges from interaction between a personal and a cultural dynamic. D, an African American chaplain visited an African American patient on a Geriatric ward. D learned from the medical chart that staff had placed this patient on assault precautions and considered him dangerous. D experienced this patient as a gentle man, who was deeply grateful for D's visit. D presented the brief encounter in a verbatim. The group, puzzled by the presentation of what seemed to be a nice encounter, wondered what D wanted to learn from the verbatim. D seemed frustrated, but struggled to articulate his need. We moved toward his feeling of frustration, and he realized that he didn't trust anyone to understand the African American experience. He finally spoke of ways he had been labeled by people who didn't have a clue. He told of walking through a grocery parking lot to the sound of people locking car doors, recalled this painful experience in the face of the incongruence between his experience of the patient and the words in the chart. In this case D's history helped him connect to the patient who shared his culture, although it was costly to D given the connections and meaning for him as a gentle and gracious African American man. D eventually trusted his peers enough to recognize how his history helped in the visit and to process the painful cultural reality this situation recalled.

This third example holds up another important area of formation (and highlights the inefficacy of the modernist claim to objectivity in scientific study). One of the most telling of

challenges to objectivity is the study of race. (Stockwell, 2002) White European Males, who conducted most early studies on race, brought their stereotyping directly into their studies. Evidence of this dynamic is demonstrated by the words they attached to the different races. The word Caucasian refers to beautiful mountains. The following characteristics given by these Europeans demonstrate the stereotyping that was normative: Europeans – white, serious, strong; Asiatic – yellow, melancholy and greedy; Americans (i.e. Native Americans) – red, ill-tempered, subjugated; and Africans – black, impassive and lazy. Some even claimed from this stereotyping that races of African descent were of a different species than human at one point in history. Such claims were based on social constructs, for the purpose of economic gain from slavery. Formation for ministry must approach this area of race as a social construct (DuBois, 1981) and raise awareness of internalized racism and white privilege inherent in those living in the Western Culture.

These stories shed light on ways engaging with an intern's history forms chaplains through integration of experience. The process is as much about soul making as teaching specific skills, allowing interns space to touch into the spiritual core of their primordial wounds. Soul making allows for integration of theory unto formation. Over and over the processes of formation for these chaplains have shown that the depth to which one is able to visit her or his own suffering is the depth to which that person can journey with another who is suffering. Otherwise, responses, even when couched in religious or scriptural response, are actually a reaction out of anxiety. It says, "I can't look at your pain so don't you look either."

### **Integration of Theory**

Integration of theory occurs by a process of combining didactic material with experience of ministry. H was an intern from a conservative sect of the Lutheran Church. His church's

beliefs eschewed humanistic endeavors and caused him to suspect any theory that was not based in scripture as interpreted through his theological hermeneutic. As the unit progressed, he recognized his experience of isolation inherent in this confessional stance, recognized that he longed for community. In the wake of a didactic on Victor Frankl's system, he saw how the focus on meaning and noetic or spiritual needs reflected a similar system as his reading of Luther. He integrated Frankl as a theoretical resource that helped him create space for the patients he served.

### **Integration of Meaning and Spirituality**

The fourth area of formation looks at one's own noetic reality, looks at the meaning one has made in life and how that meaning can help and hinder presence with another. A couple of dynamics are common as students engage this process. First, an inherent voice of judgment is a legacy of this Western Culture for most students. (Bratcher, 1985) Many who enter ministry struggle with this element of the cultural psyche. Indicators of judgment come in the form of a reaction of defendedness against anything that smells of critique, even when critique is not the motivation for a given question or response.

Given the theory calling for a non-judgmental posture for ministry, this voice of judgment needs to receive significant attention. Helping a student see the level of judgment living in the psyche and validating the reasons for such judgment demonstrate non-judgmental ways of encountering this dynamic of judgment.

Another dynamic is the shift from a rescuer who operates out of pity or because of oughts or shoulds, to someone who can participate with another through profound presence, a helper motivated by compassion, with mutuality. Once these students see the exaggerated mirrors patients can become of the students' own struggles and wounds, a new perspective forms. A

new openness to learning emerges. Such approaches as convincing or exhorting or even shaming so seldom are effective in the learning and integrative process of CPE. It creates a resistance that is counterintuitive to the kind of pastoral care being invited in this theory.

Virginia Satir speaks of this in a metaphorical story. (Satir, 1991, p. 106) She suggests that trying to get a person to open up or see some particular painful issue is like entering a room that is freezing and trying to get a person in that room to take off a blanket. In trying to talk someone into taking off the blanket, or even in trying to remove the blanket, one is met with great resistance. Shifting the process to warming up the room so that the person feels a level of comfort means that the person will go a head and remove the blanket her or himself.

The example of these dynamics of covering and uncovering, common in this fourth area of formation, demonstrate the potential in a way of supervision that focuses non-judgmentally on a student's growing awareness of primordial wounds and the noetic blocks created by those wounds. As chaplain interns and residents discover the power of these blocks along with the power of their own inner wisdom and meaning making, this integrative process creates a new depth of listening to another.

P took part in a Unit of CPE at the age of 26 in order to discern if ministry could be a vocation for him. Unlike most of his peers in the unit, P hadn't attended seminary. He grew up in a small southern town and attended his parents' Baptist Church. An accident while riding in a truck with some of his teenaged friends caused P to be a quadriplegic.

P's CPE unit took place in a medical hospital. As he ventured out into the halls of the hospital, P feared that patients would see his wheel chair and be put off by his handicap. He often experienced such muted rejection in other settings. To his surprise, his presence was well received, quite welcomed even. People suffering in various ways trusted that P would

understand their pain; because his wheelchair witnessed to the reality of the pain he had endured. This first surprise for P opened him up to the possibility of ministry.

The second surprise was a little more difficult for him to process. During the months of his recovery and the years of his handicap P had worked hard to make meaning of why this tragedy happened to him. His friends only suffered minor injuries in the accident, while he had lost so much. P drew from the belief system offered by his church; a system of thought that said God was in control of everything, that God caused everything to happen. It followed for him that God had caused his accident and his handicap. P combined that meaning with a promise, supported by his family, that God loved him. So he figured God had done this to him for a purpose. He needed to figure out how to live into that purpose. This way of thought sustained P through his recovery and in the face of the painful reality of never walking again.

P decided partway through the unit that he would like to work with children. His wheelchair prevented him from easy access to the pediatric ward, so it was arranged for him to have a ward on the more spacious Oncology Unit where children were in or recovering from treatment. After two weeks on this unit P came to one of his weekly supervision meetings. He hesitated and stumbled through some words in an uncharacteristic way and then finally began to articulate a crisis building inside.

“I always believed that God caused my accident. That was the only way I could make sense of losing so much. But I can’t believe that God caused these children to suffer with their cancer. I can’t believe God would do that to these children. I can’t see any reason or purpose for it. And if God didn’t cause their cancer, maybe He didn’t cause my accident either. Maybe all this happened to me for nothing.”

The logic of his belief system that P held onto during his early loss could not sustain him in the face of these suffering children. He entered a crisis that unwove the thin fabric of meaning that had shrouded his deep pain of loss. I admired P's courage as he faced into this crisis. These two "surprises" of his unit, the power of his presence and the loss of the theological reassurance that he had tried to offer patients as he had offered it to himself, combined to help him move into the complexity of a new way of meaning-making. Through that process, he became an even more powerful presence to others in crisis and great grief. As he faced into his own interior crisis of meaning, he gained a trust that others would be able to withstand the pain of loss and he let go of the anxiety of needing to make them feel better. The unit ended far earlier than P's process of integrating this experience and awareness. Yet even as it shattered the belief that he had used to protect him from the loss and pain he had experienced, it provided him with a far deeper integration of the potential for a sustaining faith

### **A Final Word about Formation as Integration of Experience**

These experiences give a few examples of the countless ways that formation takes place for one entering the role of chaplain. Such preparation for ministry is difficult and costly. It is powerful spiritual work born of an openness to be a life-long learner. This work means students spend time with their longings and yearnings and images of God, their primordial wounds and shattered illusions and tears. All of their religious experience is gathered up in a place of non-judgmental hospitality and inclusion. Such is the process that allows for formation of someone in the role of chaplain who might then encounter the fragile psyches and souls of those with mental illness and might offer care from an integrated and meaningful place.

## **Concluding Remarks**

In light of the theory offered in Chapter four, these descriptions of theology and formation are conclusions necessary for one inhabiting the role of chaplain working with persons who suffer from mental illness. I have attempted to offer theory to support the chaplain, creating a vision for a pastoral model for care that can live beside a medical model and can give authority in the face of religious expectations. In this conclusion I am suggesting a theology that begins with experience, and a process of formation made manifest through integration, gives a strong foundation for the theory. Certainly it has been offered in the hope that chaplains and developing supervisors might have a body of theory to guide them in continuing development of their pastoral role. Yet most especially it is offered in hopes that institutions and individuals caring for those with mental illness recognize the need for spiritual care such as is possible from the role of chaplain, and in hopes that persons who suffer from mental illness themselves encounter pastors who can offer the kind of presence that will touch and bring deep and healing care to psyche, soul and spirit.

## Chapter Six

### What's Left?

Boisen articulated a powerful vision several decades ago, a vision of spiritual care for those with mental illness. For several decades, this vision, in the context of the psychiatric hospital, has all but disappeared. My goal in this dissertation is to reawaken this vision, offering one example of theory integrated from psychological and religious resources, moored by a foundational theology and a process of formation. The theory and following theology and formative process take shape through a process of integration of personal history, theory, and theology. Experience, for both chaplain and patient, gives grounding to and offers a vital entry point for formation and for pastoral care. Through this process, a non-judgmental, highly moral, deeply caring presence may be made manifest and brought to the fragile psyches of persons who suffer from mental illness. Yet in order for this role of chaplain in the state psychiatric hospital to be utilized to the fullest, or even to come into its own, several areas of further work must occur.

#### **Building on the Wisdom in this Work**

First, because this offering of theory demonstrates only one chaplain's values, philosophy, theory and theology supporting ministry with those who suffer from the chronic disease of mental illness, an immediate need is to build on this one example. Stories relating to and supporting this theory and theology are, I believe, compelling. More such examples and stories need to be accrued by others in the field able to articulate a pastoral model. Stories emerging from this model will support theories similar to the ones offered here, will demonstrate the power of educated and integrated presence in the gap between psyche and soul, between person and other. These potential stories can demonstrate in broader ways the how and why of theory for ministry with those suffering from mental illness. Given the non-statistical narrative

approach I have named as one having integrity for a pastoral model, quantity of experience can lend credence to the narratives in this dissertation that perhaps the medical community can come to appreciate.

Another way of building on this wisdom is to collect more in the way of current theory and theology for the ministry of the chaplain, especially from persons who have moved through a process of integration at the level of life experience and theory and theology. More examples of theory and theology *from the perspective of a pastoral model* need to be created. Every year, a small host of chaplains training to become CPE supervisors write papers integrating theology, a given personality theory and a theory of education. These papers are written both as academic and as practical integrative papers. More of these integrated writings need to be published. Just this year, one journal for supervision and ministry has been revised and this first edition included such a paper. (Kalish, 2008) This trend needs to continue, and these papers also must find their way into other journals focused on medical care. In addition, people who have long been certified might take their experience and accumulated learning and write highly integrated examples of the care that they offer. This is especially true for persons who minister to those with mental illness. Also, universities have various symposiums and other kinds of programmatic offerings to which they invite a variety of disciplines. Chaplains able to articulate a pastoral model need to bring their voices to the table at such events.

Tangential to this call for publication and voicing of these integrated theories, and outside the realm of further academic work, is the issue of context. The contexts for the training that creates the CPE theory papers are normally large Trauma One medical centers. These supervisors in training receive little exposure to persons with mental illness. In the writing of their theories, they seldom have in mind the specific issues and needs and fragility of patients

with mental illness. I believe creative leadership in these hospitals might renew a focus and dole out resources for training chaplains in the context of the psychiatric hospital. While financial concerns challenge this possibility, accrediting more centers for training chaplain residents could motivate greater visibility and awareness for the special concerns of these patients. Even if these hospitals cannot sustain stipendiary CPE programs, perhaps they could serve as a placement site for students in other programs.

Building on this theory/theology also generates the question of how to clarify and broaden the concern of morality described in Chapter Five. Placing an emphasis on a non-judgmental stance toward those with mental illness challenges ethical assumptions held by many clergy. I recognize the paradox of inviting a non-judgmental stance through making judgments of the current medical model and religious assumptions. Continuing thought and study must be given to assumptions and issues of morality.

Interpretations of the post-modern paradigm from the perspective of the psychological, medical and religious professions represent another area needing further thought and study. Throughout this dissertation I have sought to offer theory of care for the human person without being bogged down in the long-standing struggle among the religious and psychological disciplines to define or nail down an understanding of self, essence, soul, etc. I have also sought to view the post-modern paradigm as a positive one for pastoral care, allowing for creative and authentic exchange between chaplain and patient, including theorists who have seen post modernism through this hermeneutic of creativity and possibility. I believe more research is necessary to build on this hermeneutic, that the theological and psychological communities could find more respect for the mutuality of their material and studies. This would include

consideration for how such terms as “self”, “soul”, “psyche”, “essence”, can be redefined or must be let go in favor of other language possibilities to speak about the human person.

For instance, at the presentation to the health professionals at my state institution that I alluded to in first two chapters, the speaker, Dr. Blazer from Duke University medical school, continuously used a phrase in which he spoke of the “folk” view of the “self”. (Blazer, 2008) He used this terminology because he didn’t have the studies to prove there was a “self”. But much of his talk stood on the assumption of the self. In his talk, he referred to one post-modern view of the self as being that no real self existed, only the wants of a given person. He went on to reclaim the understanding of a unified self that was fragmented in those with mental illness and therefore needed help, from the psychologist/psychiatrist, to come back to a unified self. While I would agree with one basis of his premise, that sometimes medication can makes a person feel better emotionally yet make them worse spiritually, his dismissive view of the self from the post-modern stance seemed facile and ungrounded.

Much more helpful in this area of consideration of the post-modern view of the self was the stance taken by Cooper-White as articulated in Chapter Four. The modernist understanding of a fully unified self that we may abandon or may abandon us, a self that is broken and needs to be repaired, is an oppressive idea. If followed to its philosophical end, it can be seen to contribute to a reductionistic view that is part of our current-day society; a view that lends itself to a dualistic stance that denies space, creates gap. I could even go so far to say that this modernist view of a unified self that needs to be fixed creates a stance of a “violent” way of education and communication. Cooper White’s post-modern affirmation of the self as many parts, as community within, needing to be able to dialogue, is a powerful image that can lend

itself to much consideration and exploration to the benefit of person's diagnosed with mental illness as well as the rest of us.

Another area for building on this theory comes from the claim made in Chapter Three in the articulation of a pastoral model. In that chapter, I pointed to the way physicians assess a patient's religious beliefs and actions, only through the lens of whether or not they are normative from her or his history. In contrast, I offered significant theory about the much broader possibility for assessment by the chaplain. Only if it represents a major shift can the physician label religious behavior as a symptom of illness, which then receives a pharmacological response. The chaplain has greater leeway to consider how any religious manifestation is or is not contributing to an experience of gap, a part of the isolation of that person from the perspective of a pastoral model. Further study is needed, and must come from the discipline of Pastoral Psychology, for making such assessments of a religious nature. This would include how to help one move through a shattered, if difficult and confusing image of God, to something sustaining of life and health. More examples of integrative work from this framework of viewing religious symptoms, and from the perspective of theological, religious, and spiritual resources could be of vital help to the chaplain and to persons with mental illness.

### **Disseminating the Wisdom**

The other main challenge and further work needed is finding ways to raise consciousness in many arenas addressed herein. If the perspective of Pastoral Psychology is to have credibility, especially for working with patients suffering from mental illness, several contexts need to be considered.

One context is the educational community which forms future pastors and chaplains. Part of the implication in looking at the sweep of history in the first chapter was to highlight the

awareness that, while CPE invites integration, seminaries are not focused on this crucial aspect of what will give ministry credibility. Rather, historically it has been assumed that academic study maintained credibility. Much like psychiatry tended to take a less than positive view of the softer sciences of therapy and social work, the academics involved in critical study of the scriptures, for instance, often has little respect for the studies of theology, especially practical or pastoral theology. Yet, as the head educator for the College of Preachers has stated, it is the person who has the ability to offer an integrated presence, who can help others with the demanding task of meaning-making, that will determine the survival of religion, and so of its many arms in the communities. (O'Driscoll, 1998) Credibility for the power of integrative work with potential to affect ministry with the dispossessed and marginalized must be seen as a most necessary extension of other more academic work in the institutions of the religious world.

In the wider context of the religious community, the challenge to communicate this material is highly complex and complicated. The very issue of the need for the role of the chaplain to stand in the face of certain religious expectations is driven by the large numbers in the religious community who hold those religious expectations; who eschew any invitation to allowing for the possibility of other vantage points. Motivations discussed in Chapter Five, power, control, the need for security in the face of powerlessness, all stand as strong barriers to any reframing of the theological and religious endeavor.

Voices from the discipline of Pastoral Psychology, even on the smallest of scales, need to be speaking from a theological stance to the souls of persons. Again and again, staff persons working with patients in my state psychiatric institution come speak to my chaplain colleagues and to me about painful tensions they are experiencing from the way in which their lives intersect with the religious expectation placed upon them. While they have more resources of

identity and stability than their patients to help them in the face of religious expectations placed upon them, they also struggle to find space; to not have their religion become guilt-dealing processes laying fresh burdens on tired backs.

A final and central question of dissemination is that of how to build bridges of communication between the religious and medical communities, especially the description of a pastoral model and the role of chaplain emerging from that model as a non-judgmental, educated and integrated presence. The communication between these two communities will not happen large discipline to large discipline, but rather within institutions as the chaplain shows an ability to offer care from an educated and integrated stance, that still has space for Resources beyond the immediate. Also, it will happen as more and more medical education programs integrate classes and conferences focused on a more holistic view of the human person. In part this means creating enough of a safe environment to allow the humanity within the medical professional to have space and voice.<sup>55</sup>

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<sup>55</sup> One doctor, as we were conversing about these issues, reflected on his time in medical school. He and his peers were shown a host of pornography films as a way to desensitize them to the human body. The same was true for the way in which he was trained to see any feeling response as negative. He retired early and was working to reclaim this vital part of his humanity. Another doctor had to tell family members that their relative, a patient in the hospital, had successfully committed suicide. A highly contained person normally, he fell against the wall afterward saying, “That’s the hardest thing I have ever done.” It was the first time he had been open to community and support.

The point of this dialogue with the medical community is not to say that this medical professional is expected to be the one who brings the total care of every aspect into the human person, including spiritual care. Medical television shows have done a disservice to the medical professions in trying to create a picture of such a godlike persona for the physician. Rather is it to raise educated awareness as to the potential and benefit of the role of chaplain and of a pastoral model that is not outcome-based to stand beside the medical model.<sup>56</sup>

Also, this dissemination of the understanding of the role of chaplain is not only focused on physicians. The same need for clarification is true of other professions under the wing of the medical model. A social worker at a specific hospice recently told a chaplain colleague at that hospice this: “Once you no longer say prayers or talk about God, but start listening to feelings, you have gone into the realm of the social worker and you need to stop because you are not trained for that.” Hospice was created to help persons have a good death with the aid of

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<sup>56</sup> The need to educate about the difference in the models that can be complementary is high. Daily chaplains note the lack of understanding of their role in the minds of all those schooled in an outcome-based model. One example from the psychiatric setting can demonstrate this lack of understanding. In moving patients to a newly built hospital, one patient refused to go. This woman, suffering from paranoid schizophrenia, feared she would not be discharged if she left. Notified of this by one staff person, I started to go back to the old hospital to be with the patient. The head of nursing, becoming aware of this said, “There’s no need to go. A doctor is there.” At best, her assumption was that I as the chaplain was going to try, where others had failed, to convince the patient to move. But I had no such agenda for any specific outcome, including getting the patient to move. Rather, I was going to offer presence to a patient who, given the message to the chaplain, felt scared and confused and angry.

palliative care and surrounded by supportive persons who were available to help people consider and prepare for their death, at every level of their being. Yet in this example, it also has been usurped by a focus on the medical model of taking vitals and dispensing meds and planning funerals. This chaplain, who created space for persons to make meaning and consider what they needed and wanted and experienced at this poignant time of life, was the most appreciated member of the team by most of the families in this hospice. Yet her work was delegated in many of the team's views to the least of what was offered to the patients in this prevailing medical model. It was the space and continuing dialogical stance of this chaplain in that situation, a stance that included her awareness of pastoral presence to the team that didn't come in the guise of specific ministry that began to create more and more of an openness to the chaplain role and the need of chaplains for that particular hospice.

This same or greater level of tension lives in the psychiatric hospital. In most medical hospitals, someone threatening suicide, at least outside of the psychiatric unit, creates a referral to a chaplain. In the psychiatric setting, where suicide ideation or attempts are a part of a specific psychiatric diagnosis, no one would think to call a chaplain as a part of the regular treatment for such patients. In fact, one study revealed the startling fact that when physicians were asked whom they would refer a grieving person to, fifty-six percent responded that they would refer to a psychiatrist or psychologist while only seven percent would refer to a health care chaplain. Yet the same study revealed that many of these physicians were from specific faith traditions themselves. Apparently their exposure to that faith tradition and the pastoral leaders of that tradition had not inclined them to consider the chaplain a person for such a referral. (Eimer, 1989) These are a few examples of the need for educating medical communities about the role of the chaplain, how that role can be integrated and offer a stance complementary

to the medical team. I hope this section highlights the great need for communication and education across the disciplines and institutions of education, religion and medicine.

### **Final Conclusion**

This dissertation has offered one model and stance for chaplains offering spiritual care to persons suffering from mental illness. If these persons are to receive care, if this epidemic of mental illness is to be treated, a shift must occur. “The stone that was rejected”, as it represents those with mental illness and as it represents the role of chaplain in the psychiatric setting, must be given a voice in the process of treatment. If this epidemic is to be treated, a shift from a primarily medical model and a shift from a religious understanding that is *a priori* an expectation of belief or behavior must take place. Pastoral Psychology in some venues has had an image as a highly esoteric endeavor. I hope that this discipline might catch the potential energy and vision to be a major contributor at this time when, in many contexts, and certainly for persons who suffer from mental illness, other models of care are not working. Pastoral Psychology, even as it lives at the juxtaposition of psyche and soul, has potential to integrate the wisdom of the religious, theological and spiritual traditions with the wisdom of the scientific endeavor. As it is given a voice at the table, and as it combines theory, theology and experience for the training of chaplains and others in positions of leadership in ministry, Pastoral Psychology has the potential to impact the care of those with mental illness throughout the world.

## **Glossary**

**Chaplain (as differentiated from pastor)** - The pastor of a given (Christian) church community has a particular framework of understanding God and the given tradition of faith that is agreed to (for the most part) by persons who are a part of that community of faith. The pastor uses that framework in a myriad of ways, to call persons out to it by way of faithful living, to nurture the faithful from it in times of strife or crisis, to invite ethical or behavioral adherence to it. The chaplain on the other hand, works with persons who come from various communities of faith and have varying frameworks, or even no faith framework. So the chaplain's role is in part listening for the spiritual resources and framework that is a part of the person before her or him, and then helping that person to draw on those resources, whether the resources themselves are ever explicitly identified or not.

At times (and in my experience more often than most pastors know), it behooves the pastor of a church to adopt more of the role of chaplain by way of helping another make meaning of a given experience as it engages with the faith framework of that person. Also, at times the chaplain is placed in a role such as worship leadership in which some resources of a faith tradition need to be utilized to create a potentially meaningful and encouraging message to a group of persons. Exploration continues to be needed to consider these roles and to allow for the diversity and difference in the role so that neither seeks to invalidate the other.

**Clinical Pastoral Education (CPE)** – CPE is a training ground normally utilized for persons in a process of formation for ministry that will involve pastoral care. The process of training is highly integrative, drawing from the individual's religious history, personal history, and adding pastoral theory and theology, understanding of cultural contexts as well as information from the

behavioral sciences. This integrative approach helps a person have a strong foundation from which to offer ministry to many different contexts. It also helps a person develop awareness of what in her or his history is a helpful resource for ministry and what may challenge a depth of presence for pastoral ministry.

**Dualism** – Different layers of meaning. In a religious or theological sense, it is referring to a way of seeing that separates our immediate experience into good and bad, or right and wrong beliefs that result in eventually landing in a literal heaven or hell. In a psychological sense, the meaning is similar, that persons separate their behaviors and other people into good or bad and are not able or perhaps willing to tolerate ambiguity. The theory expressed here would suggest that dualism is a concept born of modernity and not helpful in theological or psychological terms. The final use of dualism is that held by some few in the medical field. In this context, as it connects to the theory I am offering, it refers to a dualism of physical and spiritual. While the initial layers of theological or psychological meaning are, I am suggesting, unfortunate, this latter layer of physical/spiritual, holding both in tension, is a helpful approach, but not one often embraced in a medical model.

**Delusion** – A delusion is a fixed, false belief held by a person. It may or may not be focused on religious material. An example of a common religious delusion is that a person believes himself to be Jesus. An example of a common delusion that is not religious is that messages are coming to them out of their television when the television is not turned on. But a host of various delusions from the more specific life material and concerns present themselves in different patients. Listening for the metaphor in a given delusion can help with assessing spiritual or

pastoral issues. At the same time, it is important not to try to change a delusion for another person, especially when in a pastoral role. It is painful and disturbing to have one's view of reality challenged, and listening for the feelings that would be a part of that reality is the pastoral stance to take in the face of a delusion, along with listening for metaphorical meaning.

**Deontological** – Ethics, referring to ethical decision making by which an external rule is always applied, no matter what the given circumstances of a particular situation. It is the opposite of a “teleological” focus in which the results of an action determine the action's ethical value.

**Existential Vacuum** – Victor Frankl uses this term to describe his understanding of the existential angst in the wake of a void of meaning experienced in the culture of this age. In this designation, he wants to separate himself from the strain of existentialism that he has met in the culture; an understanding that says no meaning exists for the living of life. Rather, Frankl would suggest that it is up to the person her or himself to make the meaning that can sustain life. So the existential vacuum happens when a person has not been about this task of meaning making, embracing the challenge of how her or his unique being interacts with the world and what is given to that person in the living of life.

**Gap** – This refers to a central image used by Ulanov to describe the experience of persons who, given some life experience, large or small, experience a sense of isolation in which they are closed off from their interior sense of self and identity, and are unable to connect beyond themselves, especially or ultimately with Something Ultimate. Many causes of this gap exist that include the more global or cultural realities as well as all kinds of individual life experience.

Certainly these include major life crises, like the death or other loss of someone deeply woven into the fabric of one's life or being, or the loss of a vocational focus that infused life with meaning. Also, the day-to-day chipping away of esteem or hope or energy that accompanies difficult life experience in some settings, the stressful demands to maintain life where little energy exists for the way of life being maintained, these also are factors that create the gap. And the lack or loss of identity, for individuals or for entire groups of people also creates this experience of the gap. Frankl's existential vacuum, see in this glossary, is another potential language for the sense of gap that represents the loss of meaning in the gap experience.

**Hallucination** – A vision not seen by others present or sound(s) not heard by others present. A person may hallucinate, and know that they are hallucinating. Or a person may have a delusion about their hallucination and believe it to be true.

**Need** (or spiritual need) – I have used the word “need” throughout, with an assumption in the background of the human condition of powerlessness. Some religious thought or philosophy has named such things as needs as illusory. Yet, as mentioned in Ch. , one of the central tenets of the teachings of Jesus, the Beatitudes, begins with this acknowledgement of our depth of spiritual poverty or need, from which all other experience of need derives. Part of my theory assumes that one in the role of pastoral caregiver must be attentive to need. Many of those who have sought to disclaim having needs are those who have most wounded persons in the name of offering ministry.

**Noos or noetic** – *Noos* is a term used by Victor Frankl. It refers to the spiritual in the human person. He chose this word and the adjective “noetic” in order to have a spiritual vernacular as he wrote about the spiritual as a part of the human person. He purposefully did not use the word, *geist* which is the term used in religious understanding of spirit in order to differentiate from a metaphysical or supernatural understanding of the word.

**Pastoral** – Coined by the church as a way of describing a specific ministry of spiritual care. It derives from the image of the shepherd caring for the sheep in a safe pasture. Pope Gregory in the sixth century created a distinct ministry of pastoral care that he described as soul care and that was different from such ministries as evangelism, education or preaching.

**Pastoral Assessment** – This is a way of considering the need for care a person has from the perspective of a pastoral model beginning with the patient’s experience and utilizing open-ended narrative as a central resource. In a medical model, a diagnosis is made and treatment recommended for the purpose of a cure of the diagnosed ill. (This is true of the medical model, even when no hope of cure is possible.) In contrast, the pastoral assessment is not seeking cure or looking at persons for “what is wrong” with them, but is listening to assess some need to receive spiritual care in the face of a given felt experience or meaning made of a given event. This care may be expressed in a multitude of ways, including as iterated in the theory and theology named in these pages.

**Psyche** – From the Greek for “soul”, and the source of the word “psychology”. It refers here to the psychological make-up of a person, including the emotions and various dynamics of

relationship. In another vernacular, it is the mind part of the mind/brain split. The brain is the physiological function of that part of the body, while the psyche is the mind or thought center including meaning making and behaviors.

**Psychosis** (psychotic break) – Psychosis refers to a point at which a person has lost a sense of reality as most would describe reality and experiences either hallucinations or delusions or both.

**Religious Agenda** – Pressure to convert to a belief or system of religious thought. When this term is used in the theory or theology offered herein, it is referring to an objective understanding of some facet of religious belief, accompanied by the assumption that another must adopt this religious belief in order to be included in some way, whether included in humanity, in health, in any religious realm of God, etc. Certainly all persons in ministry stand on some foundation of belief that guides their actions. The use of the term agenda is referring to these objective criteria by which another is judged in terms of religious belief to be wanting in some way.

**Resources** – Some source of supply, support or aid that can readily be drawn upon. I use the word to indicate a couple of things. When I speak of the resources of Pastoral Psychology, I refer to the theory and theological foundation I have offered, or to other potential supports for this way of ministry, such as the memoir of persons with mental illness or other means for understanding and integrating a way of bringing presence and meaning making to the role of chaplain. The other main way this word is used in the work is pointing to the various things a person brings to the pastoral task in her or his own being, the life experience, the integrated wounds and supports, that can serve in the way of being more fully present with another person.

In both areas of reference to resources, integration is key, for without that process of integration, the resources are not available in the moment of need.

**Role** – A role is a way of being that is adopted for relating to persons in a given context. Donning a role allows for a boundaried and respectful level of caring presence for another person and allows the one inhabiting the role to have the energy to bring such presence to many persons. It is important that one's authentic being is connected to the role she or he may take on, but also that the role and the person or being are not one and the same.

**Soul** – The soul is the most unique part of a person's identity, the depth or essence of that human identity. The soul provides the sustaining sense of purpose for life. It can become depleted through life challenging experience and needs connection to some source of energy or meaning.

**Spirit** – The spirit in a human person is that which energizes the soul. It is the human force which takes in the potential and meaning in any given experience. It is intertwined with the soul in a way that is not clearly distinct in any scientific describable way. The Spirit as is manifest in many religious understandings, from the Holy Spirit of Christianity to the Great Spirit of Native American religions is an image of renewal for the human person and soul. It is a metaphysical way of connecting the universal energy, or in religious terms, God, with our human spirit.

**Spiritual** – Standing behind my use of the term Spiritual is an understanding of a process by which the Energy of the Universe connects to the human spirit for bringing new energy to the soul. Many specifically religious practices are given for this energizing process, such as prayer,

meditation, mindfulness, chanting, etc, but any activity that creates the potential of bringing new energy to the human spirit and soul I am considering to be spiritual.

**Spiritual Assessment** – Various forms of this pastoral skill exist. Perhaps the most familiar of these are the seven areas of spiritual assessment offered by Preyser. These areas include, among others, assessment in if/how one understands the holy or other, what view of providence one holds, how one is able to accept from another or give to another, what kind of community one has and how one understands activity through any lens of vocation or purpose, and if any sort of forgiveness is a part of one's understanding

**Terminal Uniqueness** – This term is used in the context of addiction. It implies an approach to life experience by those who believe no one could possibly understand the reality experienced in their lives. As a result of this sense of their uniqueness, they shut out all others who could come alongside them to offer care. They remain in great isolation. The challenge to the chaplain role in being with others living in this difficult way is to help normalize some of their experience without minimizing their difficult feelings in the wake of painful life experience.

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