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Exploring the Benefits of Spiritual Presence in Mental Health Care: A Review of Current Practice

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Abstract

Mental health issues can be so obvious in the challenges that individuals contend with, and yet when these issues are either denied or the impacts they have on the person are not addressed, the outcome is not limited to that one individual alone but all those in contact with him or her. That is because when the dignity of a person is not respected enough to be taken into consideration, such that action is taken to protect the "other", what essentially happens is the neglect of being by not adequately caring for the entrusted to us. Studies show that mental health issues tend to be prevalent among Health Care Workers than among the general population. Perhaps, these workers could find the spiritual presence of Chaplains beneficial in a more collaborative atmosphere as the day's work of patient care is carried out.

Keywords: Mental Health; Dignity; Rights; Spiritual; Chaplain

Introduction

The subject of mental health is intricately linked to the concept of human dignity in all aspects of life. It is in that framework that there is either a perception or the bias that portrays mental healthcare in a negative outlook. This negative portrayal is simply the outcome of the understanding of declining mental health as a debilitating condition. By this, we mean the gradual worsening of the social, emotional, and psychological well-being of an individual, which would not only be a personal struggle but one that is obvious to others.

To address this perception, a shift in approach is essential—one that recognizes the complexity of mental health while embracing the inherent dignity of everyone. This paradigm invites a more nuanced understanding, acknowledging that mental health challenges are not mere deficiencies but experiences that shape and inform a person's identity. It necessitates a blend of compassion and practical engagement, steering away from stigmatization and toward empowerment. By seeing mental health care as a collaborative journey rather than an imposed solution, caregivers and patients cultivate a mutual space of trust and growth, setting the stage for holistic healing [1].

This portrayal, however, often overlooks the intrinsic human dignity that remains intact despite the challenges of mental health struggles. It is this dignity that calls for a deeper and more compassionate approach in mental health care—one that recognizes the individual not merely as a collection of symptoms but as a person with aspirations, relationships, and values. Spiritual presence becomes a vital component in this framework, offering a lens through which care providers can connect with patients on a more profound level. This approach shifts the focus from mere symptom management to nurturing the whole person, addressing their emotional, social, and spiritual dimensions in tandem with their psychological needs.

Spiritual presence, not to be confused with strictly religious or faith teachings, in mental health care bridges the intersection of human values, emotional depth, and existential meaning. It is at the very centre of human identity since it essentially brings about the connectedness of both patient and caregiver, bringing each into a personal relationship at the core.[1] It recognizes that the human spirit, often shaped by faith, philosophy, or personal reflection, is an integral aspect of one's identity and resilience. This approach does not aim to impose belief systems but rather embraces the patient's own spiritual framework, regardless of an individual's faith tradition, if any, reinforcing their capacity for healing and self-discovery. By addressing the spiritual dimension, caregivers can offer a more holistic approach, one that aligns with the multifaceted nature of mental health needs. It is in this union of the physical, mental, and spiritual that transformative care finds its foundation.

By integrating spiritual presence into mental health care, practitioners acknowledge the profound interconnection between an individual's inner world and their external challenges. This perspective fosters an environment where care goes beyond treatment, embracing the existential questions that often accompany mental health struggles. Such an approach empowers patients to find meaning even amid their trials, reinforcing their sense of identity and purpose.

This transformative care framework further emphasizes the importance of recognizing the unique journey of each patient, where their lived experiences and personal narratives are central to their healing process. By integrating spiritual presence within this journey, caregivers can foster a therapeutic alliance that transcends traditional clinical boundaries, creating a space for profound empathy and mutual understanding. Such an approach validates the individual's emotional and spiritual experiences, empowering them to reclaim a sense of agency and purpose amidst their struggles.

Moreover, this model encourages mental health practitioners to cultivate their own sense of presence and mindfulness, enabling them to connect more authentically with those in their care. Through practices such as active listening, reflective dialogue, and a willingness to engage with the deep existential questions that often accompany mental health challenges, caregivers can offer support that resonates on a human level. This not only enhances the therapeutic process but also reaffirms the shared humanity between caregivers and patients, underscoring the essential dignity of both parties.

Recognizing the profound interconnectedness of mental, emotional, and spiritual dimensions necessitates a shift in institutional priorities. It calls for mental health care systems to adopt policies and training that equip professionals to integrate these dimensions into their practice. By doing so, the healthcare system moves closer to addressing the broader social and systemic factors that influence mental health outcomes, ensuring that care is as equitable and inclusive as it is compassionate. The idea of human dignity is foundational to the concept of human beings. This is because only when there is a particular life to which we become responsive, that one can lay claim to human dignity in life as it flourishes. Dignity, in mental health care needs, is not in any material form nor in a particular moment of decision making that we could be tempted to say it lies in patient informed consent, or doctor-patient relationships. Dignity is an intrinsic part of human life, and its goal is human flourishing [2]. Thus, dignity is *simply* who we are, and in being able to live a *good* life.

The objective of this paper is to reflect on the life of the Ministry as a chaplain in various hospitals, as well as nursing care facilities. There would be emphasis on the time spent with patients mainly for mental health care support. Somewhere along the journey, I applied for Chaplain's position at Western Psychiatric Institute and Clinic (WPIC henceforth), a major University Hospital.[2] My role was to provide spiritual support to patients and staff. We had group sessions weekly during which patients freely discussed spiritual or faith matters, and most importantly the group dynamic offered somewhat of social support to some of the patients who needed it most at that time. The background of patient population was primarily dual diagnosis. In some cases, there would be staff present there with a couple of patients if it was thought that they could be disruptive to the program, which rarely happened. At other medical institutions where I have worked as chaplain, I have been involved in the care of patients who were set aside for psychiatric consultation.[3] In those encounters, I learned not to make any assumptions about what the patient had to tell me but to listen attentively and repeat everything as an affirmation to the patient that I am fully present. By doing this, I have been corrected when I hear something incorrectly. This is important because it is the patient's own story regardless of whether it is fiction or not. In my experience working with patients who are undergoing mental health care, apart from their regular treatment regimen, they tend to attach much importance to human connections as I observed during my

1 At the core of the human person lies conscience. It is an internal faculty that is natural to the human nature, which helps us make right judgements. (1Cor. 4:4)

2 This was Western Psychiatric Institute and Clinic in Pittsburgh, where I was employed as the Lead Chaplain after serving as a member of the Spiritual Care Team of the Presbyterian University Hospital for some time.

3 One instance of a medical setting where I worked with individuals on issues of mental health care needs was Geisinger Medical Centre, In Danville, Pennsylvania.

visits and while providing care. It was unmistakably noted through my own visits that such human connections had the likelihood of moving the patient towards the goal of attaining wholesome health. To effectively attain the objective set out in this paper, I will first do an overview of the life of Ministry as I experienced it in patient encounters. It was in this context that the encounter between those individuals who need mental health care support, and the caregivers came up. Also, there are varied classes of caregivers. It could be nurses, doctors, physical therapists and many others. But, the focus of this paper is on the author as the spiritual caregiver, in ministering to others in their time of need. Second, I will make a moral reflection on what I have presented. By this, I will be drawing on moral concepts, as well as principles to analyse some issues that come up in the discussion thus far. The individual's right to dignity will serve as a reference point for this discussion. Finally, our conclusion will summarize the discussion with a clear narrative on what our stand is on the issue put forward.

Personal Story

Rather than consider this next part as an autobiography, it is an account of my personal experiences and encounters with patients during a period I ministered as hospital Chaplain. I find it compelling sharing this as it serves as a backdrop to help us launch our discussion on dignity and mental health care within proper ethical limits. During the training for Hospital Chaplaincy, one of the things the student-Chaplain is made to be aware of is that, while approaching a patient's room, all assumptions or preconceived ideas on who this patient might be or what may have brought the individual to the hospital must be put aside. One simply goes in there to present the self to the patient as "is" by engaging the individual in the present moment, letting the patient take the lead on that journey as uncomfortable as that might be at times. Not long after my priestly ordination, I was assigned as chaplain to a Children's hospital, as well as a Nursing Home. I once got a call from one of the Children's Hospital Social Workers for the Psychiatric Unit one late afternoon, to visit a patient who had been admitted for eating disorder. The reason the chaplain was called in was because her parents were becoming concerned, as not only was she not keeping her food down, but she also started manifesting obvious marks on her body, evidence of attempts made to hurt herself. Upon entering her room, I noticed that the patient was sitting on the floor all couched up in one corner of the room, barely did she make eye contact as I entered the room and approached her where she was sitting on the floor. I greeted the patient and introduced myself. As she was not responding, I stooped down low and gradually sat on the floor, almost but not directly across from her. When I sat on the floor, the patient finally looked at me without saying a word. When she did, I asked her if there is anything she would like to share with me. I assured her that I have her best interests at heart, and I am there together with other caregivers, working for her good. It was only then that the patient started sharing how she just did not feel okay whenever she eats, and all she wanted to do was to rid her body of any food she eats. This has been her experience, one she genuinely struggled with. Arthur Kleinman explains the difference between illness experience and illness problems [3]. The above patient's illness experience has been described in the patient's own words. For the patient, this experience is "real", for the fact that she would try to find means to free herself of something considered "burdensome". Her illness problems are at a different level whereby she seems to be in pain seeing how no one seems to understand, or perhaps when it appears that no one is interested in understanding what she is going through. Patient's pain does not stem from just being alone as it may seem ordinarily, but the lack of a "listening" ear[4].

Needing to be connected to the other is a powerful factor in human life, particularly in difficult and challenging times. That is one thing I have learnt over and again in my ministry. Underlying this need may have to do with the spiritual or psychological aspects of human nature, which I am not about to get into, but it is obvious and there are times when its influence, when not properly addressed, can become a distraction rather than a positive force in rendering mental health care. G. K. Chesterton observes that when an individual engages in a thought process with no clear purpose, the outcome is that the one does not achieve any "clear end". The "end" here refers to having a foundation from which one could easily make other decisions, and if earlier thought process lacked purpose, it simply means we are looking at a life of crisis. Chesterton describes it as:

" . . . without the proper first principles go mad" (*Orthodoxy*).

The other factor recognized for keeping people sane, according to Chesterton, is described as Mysticism. What this refers to is that element of mystery in life that one is called to embrace, and within that realm, the human person thrives despite all the odds as long as the individual clings to hope. Chesterton opines here that there is indeed a healthy place for doubt in our lives, and that is what the ordinary man has done: "He has always left himself free to doubt his gods", and by being able to doubt the worry of certainty and its problems would no longer be a burden.

4 According to the Resolutions adopted by the Human Rights Council of the United Nations General Assembly on Mental Health, such "listening" ear could not be taken literally and reduced to a mere physical ear. Rather, it underscores the importance of wellness when mental health is being addressed. Unless, when there is a complete physical, mental, and social well-being, not simply the lack of disease (United Nations, HRC/RES/36/13, 2017).

In his work, *Orthodoxy*, G.K. Chesterton opines that a Christian is one who acknowledges that the universe is diverse, and that the sane man is aware of his complex nature. In other words, these individuals are very much aware of the lack of constancy in nature. The sane man is also very much aware of the fact of his beastly nature, as well as a touch of the citizen. Chesterton further identifies another type of individual, the madman. This type of individual portrays a simple worldview and, and a sure one as well. The reason his worldview is so simple is because he considers himself sane, while he sees others as insane [3]. This essentially means the sane person identified above is the type who can reflect on the self and take that step toward being separated from the material world to be able to identify both the individual and social values required of one and respond to them. By reflecting on what Chesterton had to offer to this particular discourse that spans across mental health care and living out the Christian faith, it became obvious during my ministry as I try to make meaning of what I struggled with from day to day, providing support to patients who were in treatment mostly because life had come to one thing or the other, and it was destructive. But this simply shouldn't be the way! We often did agree on my initial visit to patients but, coming out of such patients' rooms I felt the need to go back with my instinct telling me that "this is the one who needs you". Indeed, it worked out to be that way most of the time, not always.[5]

G.K. Chesterton argues that individuals whose connection in life rely solely on material things and others who lack mental stability (those described as madmen) never have doubts [4]. One obvious reason for this could have been easily explained away by a certain characteristic of such individuals that makes them attached to particular things or certain ideologies, and perhaps their noncompliance with treatment, which may have complicated their chances at recovery. As a result, such a class of individuals tend to see others, in fact, any one different from their vantage point, as a threat to their wellbeing. This is because, it is either that a patient has come to accept his/her situation as a coping skill, or in reaction to what he/she detests.

Jane was a patient with whom I worked, who struggled with Dual-personality disorder. She came into the clinic on a regular basis for extensive therapy apart from her regular medications at home. During one of her in-patient sessions, I received a message saying she wanted to have me visit. There was also a standing doctor's order to have spiritual Care visits which had been going well. On that occasion, Jane was a different person. Upon entering the Social Activities Room where she sat waiting, she observed a pen in my chest pocket and went straight for it. She threatened to stab me with it while asking repeatedly "Are you now one of them?" Jane had refused to cooperate with therapists before this time. She had not taken her medication either. But she wanted to talk with me. When I got there, I also became a suspect when she started asking, "Are you now one of them?" Jane was a teenager, with no family living nearby. She had to travel over four hours to get to the clinic each time she came for this extensive treatment. To help her recall what my role was, I did not answer her question directly. Instead, I gently tried to explain to her that I was there to support her, and I underscored this by relating my visit to previous visits when she noted that she had a wonderful experience talking with the Chaplain. In this vein, I asked the patient if she felt the same way about the care provided by other staff members, or at least some. My goal was to get Jane down memory lane to recall any moment in time when any member of staff apart from me may have worked with her and left a positive impression on her. She gave no answer but simply asked me to sit down, which I did, and we started talking about various things. I asked for my pen, which she needed to examine thinking it was a disguised recording device. This visit must have lasted about 35 minutes after which Jane was open to the idea of my calling her nurse to bring her medication.

During the course of any given day in my hospital ministry, the requests for Chaplain that came to me were not all sacramental in nature. There were others whereby patients simply just wanted the Chaplain to come by and talk with them, or the doctor had put in an order for Chaplain's visits. These latter ones proved to be more demanding from my experience, those patients tend to have a lot to talk about, which means one needs to be patient in listening to their story even if all that is required is to listen. After a while, as I reflected on this experience, I got the impression that the act of "reflective listening" whereby I did not simply hear what the patient was telling me but actively participating in the patient's journey and offering support as needed, perhaps, has its therapeutic purpose in patient's overall treatment plan. In some situations, a follow-up might be required and when that is done, it means a whole lot to the patient.

Lastly, I earlier made mention of having worked as a Chaplain at the Western Psychiatric Institute and Clinic, which is part of the University of Pittsburgh Medical Centre. At the time, there was a concern on how frequently some patients were getting re-admitted, especially among the dual-diagnostic patients. Once every step was taken to address their treatment to ensure they were getting all that was needed, it was also considered necessary to address their social support system once they were discharged to go home. This was where Spiritual Care was helpful to these patients' discharge process. Many of them welcomed the

5 I need to state at the beginning here that due to respect for patient confidentiality, I cannot go into details of encounters I had with patients. Also, if any name is mentioned, it would be fictitious and not real names of patients.

Chaplain's visits regularly during their hospital stay. So, they were asked if they would want Spiritual Care to help advocate for them in the community with a local Church (Mosque/ Synagogue) of their own choice for continued support and visits. It was explained to these patients that all the hospital was trying to do was facilitate a smooth discharge for them to ensure there is a support network out there to assist them when they needed one, and the fact that they need to give their consent for it to happen. We also explained to them that whenever they do not need that support anymore, they simply call the group and stop the arrangement. While this initiative may have been put forward by Spiritual Care at the time, it took the support of one of the Vice Presidents, Social Workers, and Nursing departments to make it work. Where we have a patient population longing for a service that a Care Team is both adequately equipped, and willing to provide, then the guardrails in place should be as few as possible. If there is any, such guardrails should not prohibit discharged patients from wanting to reach care providers of their choice in critical moments that could make the difference between life and death.

Moral Reflection

The ***Universal Declaration on Bioethics and Human Rights*** stresses that dignity is an inalienable quality of the human person for the fact that not only could one not be deprived of it no matter how hard anyone or an authority may try to, here it is the world body that has formally laid down universal action-guides for nations and states, as well as Communities on how to promote respect for human dignity (*UNESCO* 2005, Art. 2a, b, c). Simply stated, dignity isn't all that rather mysterious. It begins with the rights of the person that is part of daily life, which could either be positive or negative rights. A right is positive when an individual is not only able to lay claim to certain privilege, but there are others who equally have a duty to provide certain resources to the individual as well, to guarantee the right of the individual. Negative right, to the contrary, appears prohibitive in nature, given the right of the individual is one that either restrains one from certain actions or limits how far one could go [5]. When the freedom of the person to live a fulfilled life is acknowledged, as well as their right to those necessities that make life meaningful possible, then we start to see ourselves wanting to not just respect their dignity but also to protect their human rights if and when threatened. And that is one reason why there is often the need for consultation in mental health care, or the patient's refusal to comply with treatment. It is all because someone feels his or her "person" is either not respected or that the individual was not involved in the decision-making process that culminated in that treatment. This would often make patients suspicious and refuse to accept medications from caregivers. Without respect for the basic rights of the person, patient or not, dignity lacks foundation [6].

The instance of Jane above is not particularly different from this. The fact that a patient may have been coming regularly for treatment to an institution does not excuse caregivers and all other staff from doing all that needs to be done to help that patient make the experience as smooth as possible. Being in the hospital can be traumatic for some individuals, and if the condition is unknown and of a serious nature, it further complicates the situation. Individuals respond to situations differently and caregivers should try to be mindful of this always. So, preparing patients for admission should be of utmost importance and information sharing and the participation of the individual should be such that it is ensured that the patient demonstrates a reasonable degree of cooperation in that process of consent. By this, the standard with which what is reasonable is to be determined would have to be the patient *per se* as not all individual situations are expected to be the same. It should also be made clear to patients that staff is always available to explain information that needs further clarification at any time. The current informed consent process is often done at the patient registration in hospital or upon admission, right before treatment commences and the goal at that moment is to have patient "sign" the informed consent document and have it on record. There must be a more proactive way of approaching the informed consent process, that puts the good of patient at the forefront, without compromising the ethics of consent process.

Also, as spiritual care provider for patients, though I served many patients in other capacities like counselling, I often struggled as I saw myself walking a path I never could have imagined finding myself on had it not been for the type of ministry I had suddenly developed interest in. Yes, I felt called to hospital ministry and until the time I took up the position at WPIC, I had previously responded to "psych" requests (as popularly referred to among us, Chaplains) as though they were distracting me from visiting other patients and I tried to keep them "locked away" till the end of the day when I addressed them. What changed that perception, for me was the encounter with Jane. That encounter could best be described as an awakening that suddenly challenged my belief system to its core. At the time, I was just making a transition from a medical facility to a psychiatric one. I felt confident enough, at least that was my impression and understanding, as I was made to believe at my interview, of what I was going to be contributing to the spiritual care department. However, Jane's question made me suddenly realize whether I was being realistic and able to connect with patient's real needs positively or if I was just going to be putting together lofty ideals that are of no practical importance to patients. Jane herself presented me with the picture of that world patients had to deal with, and the choice was mine to make. It is only within this framework that any caregiver who genuinely seeks the good of those under one's care would focus, not on the self

but on the "other" when patients tend to challenge one out of desperation, fear, or due to life uncertainties resulting from patient's condition; and it is at that moment that the caregiver is challenged to work positively in assuring and comforting the patient. The Chaplain, who is regarded as a caregiver within the health care system together with other health professionals, are all expected to provide the above services to patients in an ideal manner.

The principle of respect for persons underscores the importance of the dignity of everyone, and that each person must be accorded respect and protection (The National Commission for the Protection accorded to the Human Subjects of Biomedical and Behavioural Research 1979). What this principle calls for is neither arbitrary nor is it too far away from what spiritual care does in the life of patients. Acknowledging the dignity of another might mean recognizing that they too are endowed with reason and are able to make choices, as well as being part of decision-making. It could also be, rather than locking away what our discomforts are, we engage them and learn what the issues are, and make that a learning experience, which could then become a growth opportunity for all. This is because, if one approaches life situations with a clear conscience, relating to another can be easily established since obstacles posed by such things as inequality would be less problematic. When a Chaplain journeys with a patient, or perhaps a Staff member, that journey could lead anywhere. The road on that journey is a choice not made by either of the two parties. It is because the Chaplain is there to serve one in need, and to be of true service, one must allow the "other" to be vulnerable, i.e., truly open up so that in that moment of being vulnerable, they can experience a loving and supportive presence. This is why individuals are urged to act in a "spirit of brotherhood" (UNESCO 2005, ART. 1), which essentially means doing what is right always. Hence, a Chaplain seeks to establish that "relational presence" with the patient, one that affirms the importance of the patient's person as key to the decision-making process, as well as the binding force that brings all members of the Care Team who are committed to working for the good of the individual patient.

Similarly, the United Nations played a greater role in ensuring that the rights of every individual are not just protected, but that they can speak for themselves by expressing their own interests and wishes once they have attained a certain age, and those interests that are expressed should be taken into consideration for the individual's best interests. In discussions on the care of the mentally ill, there is the concept of the emancipated minor[6], which is not our focus of discussion in this reflection. Rather, we direct our attention to the document on rights of individuals (the child), which is considered foundational regarding the dignity of the person when it pertains to mental health care.

Conclusion

The dignity of the human person is neither a material object that can be fixed just like an automobile, nor is it just like any of many things we can choose from on a given day as we try to decide what to put on to make one look good. Perhaps, there might be one day that the colour combination isn't quite right, or the dress simply doesn't go with the occasion. These are all externals and although, one may feel that the worth of a person is in the external appearance as to the extent we go to look in certain ways; human dignity actually lies in one's ability to develop an interpersonal relationship with others, having realized that this relationship is based not on anything physical but on a goal that is of a transcendental nature which all individuals share in common. It is on this that mental health care should be grounded.

Having addressed the role that the spiritual care provider plays in mental health care in this reflection, this work intends to evoke a more positive response from, not only those who are direct caregivers, but those who take actions that in one way or another impact the entire mental health care landscape. By this, we mean policymakers. Particularly the policies that bear directly on patient care need to reflect actual realities of real lives of patients and the concrete situations of daily living, for when those policies tend to be too abstract, they can only complicate the situation for the patient and their caregivers. In some cases, it's a matter of life and death.

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