The Linacre Quarterly

Volume 37 | Number 1 Article 12

February 1970

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Rev. Thomas S. Forker

Rev. Thomas S. Forker was ordained in 1942, after studying in the Minor and Major Seminaries of the Diocese of Brooklyn. He took special courses in Social Action at The Catholic University, and in Basic Psychiatry at Brooklyn State Hospital, New York. After being in parish work for 12 years he has now been the Catholic Chaplain at Pilgram State Hospital, Brentwood, New York, for the past fifteen years. He is at present the President of the Association of Mental Health Chaplains. Father Forker is a member of the Executive Committee of the National Guild of Catholic Psychiatrists.

The mental hospital chaplain is in a unique position to take a comprehensive view of the care of the mentally ill, in the past, the present, and as projected in the future. In many facets he is not directly involved, and can take the position of an interested observer. He has a box seat on the fifty yard line.

As far as actual treatment was concerned, for a long time there was very little the psychiatrist could do for his patient in the institution. Custodial care was the order of the day, and the patient was housed and fed, and protected from harming others or being harmed himself. It was a frustrating period, and was probably best characterized by the publicity in the Psychiatric Journals, which offered more humanae restraints, safety windows, unbreakable feeding utensils, and hydrotherapy tubs.

Then about thirty years ago the dam was broken. One treatment after another was discovered, enjoyed its moment of popularity, and was replaced by something new. The convulsive therapies – Insulin, Metrazol, and Electric – and even pre-frontal lobotomy all enjoyed their day.

With the discovery and introduction of the various synthetic and natural chemical agents, a whole new day of treatment possibilities dawned. Many patients who had been in the hospitals for years were either able to be released, or at least no longer needed the mechanical restraints and locked doors of the past.

And all the time there have been those who think of themselves as the "real psychiatrists" – who would only use psychotherapy. They frequently spoke harshly of the "buttonpushers" and "electricians" in the past, and now say that the "pharmacists" really are not curing people with their Chemotherapy, but have merely discovered a new way to control them. Actually the amount of psychotherapy done in institutions has been minimal. The technique does not lend itself to the large numbers involved, and is prohibitively expensive and time-consuming.

All across the country there has been a dramatic reduction in the in-hospital census. However, there still remains a big job to be done. Many departments of mental hygiene are now pushing the idea of "Milieu Therapy", and "Unitization."

The New York State Department of Mental Hygiene has been running a series of interdisciplinary conferences on "Maximizing a Therapeutic Milieu". These bring together representatives of the various disciplines in the hospital – not only the regularly recognized treatment services, but also the supportive services and ward personnel on every level. The aim is to spread the doctrine that every moment of a patient's stay in the hospital should be therapeutic. Even in the absence of the doctors, the brightly painted walls and pleasant surroundings as well as the therapeutically-oriented night attendants, are "treating" the patient.

This is a very interesting idea, even though it can hardly be called completely new. Anyone who has been following the literature will remember that even 25 years ago there were articles on the good results obtained by providing cheerfully painted and comfortably furnished day rooms and dormitories. And it has long been known, among the lower echelons at least, that many patients profited more from concerned and interested ward-employees, than from seldom seen doctors.

Carried to its most extreme form, this milieu therapy is practiced in so-called "Unitized Programs." This involves all who in any way treat a patient or provide for his needs not only in *acting* with the patient but also in diagnosing, planning treatment, and finally evaluating the results and releasing the patient.

The theory on which this new treatment is based is interesting. It assumes that by total involvement the strengths of all will be coordinated to help the patient. However, in practice there are many difficulties. It demands a great amount of re-education on the part of every person, and a willingness to "blur roles" – that seems a bit unrealistic. There is further a bit of fiction involved. While the doctor may sit in the unit-meeting and be outvoted, nevertheless by law he is the one responsible. I am sure that, in case of problems, public opinion would take a very dim view of any serious decisions being made by those who have no formal training or background, and no license which would make them responsible for their actions.

We shall have to see how these new theories work out in practice.

Looking to the future we are told that the day of the large mental hospital is coming to an end. The National Institute of Mental Health is looking forward to the day in the near future when all patients will be cared for in Comprehensive Community Mental Health Clinics. The patient will never leave his neighborhood, but will be cared for, part or full time, in Clinics, Day-Hospitals, and various sheltered situations. Only in a very few cases will a patient be committed to a full-time custodial institution.

Again, as an ideal it is most interesting. However, the very obvious difficulties that arise make one wonder if it will ever be actualized. The almost insurmountable difficulty will be that of personnel. Right now the large institutions use the available psychiatrists, psychologists, and social workers in the most efficient way, and there are never enough to go around. Every American Psychiatric Association convention sees the Departments of Mental Hygiene of various States bidding against one another for the always too few qualified people. The new plan will use people in the most inefficient way, dispersing them in many small centers, leaving it up to the patient to get himself to the clinics for treatment. In view of the fact that most patients never feel they need treatment anyway, it would seem that we will have to arrive at some new kinds of mental illnesses, which motivate patients to seek help, if the Comprehensive Community Mental Health Centers are to function.

Looking out from his box seat in another direction the Chaplain sees that the acceptance of Religion, and its ministers in the Mental Hospital picture has undergone many vicissitudes.

In one of its first meetings, back in the 1840's, the Association of Lunatic Asylum Superintendents, which grew into the APA, considered the desirability of having Chaplains in such asylums, and came to the decision that it was most desirable indeed. From that high point we find that the full gamut was run. With the popularity and even the ascendency of the Freudian point of view, we find a positive antipathy between Religion and Psychiatry, and a correspondingly disinterested attitude toward having Chaplains in Mental Hospitals. Indeed in some cases, there were even prohibitions against clergymen entering institutions. In New York State, for example, all of the older institutions have had Chaplains throughout their histories, usually supplied by the various religious bodies. But in the younger institutions such was not the case. It was not until 195[illegible] that Chaplains were recognized as part of the Staff, at which time they were appointed as Resident Staff Officers.

It seems that the wheel has yet another turn to make. The writer – President of the Association of Mental Health Chaplains – has been informed that the current Church-State furore has caused at least one state – right in the middle of the Bible Belt – to do away with the title and the position of Chaplain in its State Hospitals. And so the patients, deprived by their confinement in the State institution from freely satisfying their religious needs, will now be prepared from having such needs met by Chaplains.

The State is redesignating the Chaplains as "Counselor", and has reworked the job description to reflect this change in emphasis.

It is true that there have been many Chaplains who have thought of themselves principally in this light. However, as far as the majority is concerned, the Chaplaincy is occupied with the full exercise of the Priesthood. Counseling will have a place, but only as part of the greater picture, which centers principally around those things which bring men closer to God, and God closer to men.

It is unfortunate that some of our own young men, priests or seminarians, who are preparing themselves to be Chaplains seem to have a mistaken idea as to just what their job will be. They are anxious to take courses in counseling, psychology or social work, feeling that this will make them better Chaplains. Of course all knowledge is valuable, but they should be advised not to "blur the lines" as to what a Chaplain is and does. If the young man is trained and skilled in counseling, psychology or social work, and wishes to act in these fields that is fine. But the hospital will still need a Chaplain who will take care of those many things that only a man of religion, working as such, can do.

The Chaplain from his 50 yard box seat could also look at the changes that have come about in the staffing of the hospitals. Many, still active in the field of institutional psychiatry, can remember when the general rule was "underpay and overwork." The jobs on the lower levels were taken frequently by those who could find work no place else. There were "Hospital Bums" who had worked across the country, floating from job to job. Now the upgrading of pay and the training which is given to new employees, has in many cases made the positions in the hospital more desirable, sought after, and held permanently.

On the higher levels there have also been improvements made. There have always been dedicated men who trained in psychiatry and then stayed in the mental hospitals instead of going into private practice. They frequently worked their way up in the system to positions of authority, and many of the overall improvements have come from such men.

However, for a number of years, as the census figures were climbing in every hospital, anyone with an "M.D." could find a position in a mental hospital. Many were refugees from war and persecution. Some had been skilled and recognized in other specialties abroad, but now with no license they could practice only in an institutional setting, they became "psychiatrists by Catastrophe". In this particularly "verbal" specialty, they frequently had little or no English, and unfortunately little interest.

The medical profession itself pushed special examinations for the graduates of foreign medical schools which weeded out many of the less able. At the same time the increased salaries and higher professional regard seemed to be encouraging more well-qualified American men to enter the field.

Such is the view from the 50 yard line. One of the problems about tracing progress is that sometimes it might seem that one is finding fault with the past. Sometimes in praising what has been done one may almost seem to be condemning the men who in the past worked with things as they were. When we speak of the dark painted wards, the heavy (unthrowable) furniture, the restraints and the heavy duck strong-suits (untearable) we have to avoid the mistake of speaking as if the psychiatrists of the past continued these things by an almost callous purpose. We must recognize that men of good will were making do with what they had. Their dissatisfaction sparked the research that brought about some of the discoveries. It was the driving interest of those who worked with less that gave us the "more" we enjoy.

Progress has been made. It has not always been a straight line. As in most other human undertakings there has been a step backward now and then, but on the whole we can report improvement. We look forward to even greater progress in the future.

The Chaplain can have a very great part to play in that progress. New discoveries and greater knowledge can of themselves never help anyone. These things have to be put into practice by men. The unstruck match lights no fire, and the unused ability will not help the patient.

The Chaplain can help motivate all concerned by the insight he can contribute. More perhaps by his attitude toward each patient as a child of God than by his words, he can move even an overworked staff member to keep trying. And on the side of the patient he may, by treating him as of value cause him to feel valuable, and so worthy of being helped. As the representative of a loving Father, he might help this group of God's children to act and react with love.

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