The Mental Hospital Chaplain: A Review

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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 Pilgrim State Hospital, Brentwood, New York, for the past fifteen years.

He is presently 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 the projected in the future. In many cases he is not directly involved, and takes the position of an interested observer. He has a box seat on the fifty yard line.

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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 idea 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 everyone, and a willingness to share roles. This is a very interesting idea, and 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.

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.

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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.

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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 efficient 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 will 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, reaching that high point we find that the whole gamut was run. With the popular and even the ascendency of the Presbyterian point of view, we find a positive antipathy between Religion and Psychiatry, and a correspondingly uninterested attitude toward Chaplains in Mental Hospitals. Here Chaplains seem to have a mistaken conception of clergymen entering institutions. In New York State, for example, all of the older institutions have had Chaplains throughout their histories, usually supplied by denominational, but they should be advised that religious help is not to “blur the lines” as to what a young chaplain is and does. If the young man really is not a trained and skilled in counseling, Chaplains are recognized as part of the Staff, at which time they will be next to job. Now that only a man of religion, another turn to make. The writer - President of the Association of Mental Health Chaplains - has been informed that the Chaplain from his 50 yard box could also look at the changes which have come about in the training of the middle of the Bible Belt - to 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 might 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 been many 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 particular “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 washed out many of the lessable. 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 (un tearable) 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 see 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 smile will not help the patient.

The Chaplain can help motivate a concern 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 worthy of being helped. As the representative of a loving Father, he might help this group of God's children act and react with love.

In medicine, I think, everyone listens to his own music. Not only do we spend most of our time reading our own journals, and listening to our own specialty, but I suspect psychiatry may not be alone in listening mostly to its own school of thought. This Journal offers not only the opportunity of sharing ideas with other specialties but especially a chance to talk of "Family Psychiatry" for a group with a special commitment to the stability of the family.

I want first to review how family therapy differs from the better known analytic approach; to offer some observations on family processes common in many families and voice my concern that the family therapist is headed out of medicine.

Psychiatry entered the 1950's in this country, with much enthusiasm for psychoanalysis but growing concern about its limitations. Extensive training was required for the small numbers of qualified doctors who could treat a relatively small number of cases. The fascinating work being done with schizophrenics by a number of gifted analysts was not widely known, but even when recognized, was cold comfort to the mental