Mental Health: the hidden community

You cannot save people, but you can love them. And that just might be enough. (Anon)

Introduction

Perhaps I should say right at the front of this paper that I am not drawing on accademia. I work pastorally in the field of mentally health chaplaincy, and live and work reflectively. It is this reflection drawn from my lived experience of applied theology which will form the basis of this paper.

I trained as a Methodist Minister in the British Connexion, and was received into full Connexion in 1990. I worked in a number of suburban and rural circuits, finally ending as superintendent at a rural circuit in Cornwall. Throughout my ministry I have been dogged by chronic depression, with recurring acute patches: so when the post of chaplain to Mental Health services for the west of the county became available, I applied (and was very surprised to be successful). At the time, although I had personal experience, and the sort of awareness of mental health issues that one gains from a life in pastoral work, I knew little of the community which surrounds those who suffer from mental health problems, their carers and the staff who work with them. Nor was I aware of the many large theological issues which I would come to face.

The community

Until I became a member of the mental health community, I have to admit I did not really know it existed. Do you know the bulk of the patients with whom you share a GP? Do you keep in contact with people you have shared a hospital admission with? Do you greet the nurses when you meet them in the supermarket? This is the community of those with a long term illness: “Severe and enduring mental ill-health” is the term we use. Increasingly, those with mild or even moderate illness are 'screened out' by a cash-strapped service.

For me, the discovery that the mental health community is so close knit was the first surprise. People who have been 'in the system' for years or even decades have met each other, shared opinions about good or bad staff, swapped cigarettes in the ward smoking areas, supported each other through difficult times and got to know and care about each other at their most vulnerable moments. Often they have been able to provide support to each other, even if it just calling a nurse in a crisis.

The community, like any community, has its own language. Formed from the sections of the Mental Health Act and the names of treatments, only a member would know what it means to be “5.2ed”, how humiliating a 'depot' is, or the privilege of “Getting section 17 leave”. It also has its own characters, generally referred to by only a first name, as everyone knows who you mean. It has shared grief for members who have lost their battle, who are spoken of in hushed tones and sorrow.

This community of people show a very deep level of compassion towards each other. There is a great willingness to share – people who have nothing will give away what little they have. I have seen someone break their last cigarette to share with someone who has none (they are almost a currency in an inpatient unit). Staff have to exercise care that patients don't give away too much. Or that patients are not burdened by their care for others when they have their own difficulties too. In my first few months and years I was constantly astonished at finding a level of generosity I had not found in any other section of society. I recall a patient who went out for a walk to the shop, and

returned with a cheap bunch of daffodils which he handed to me “Because you looked like you needed cheering up”. Being a member of such a community is a real privilege.

The community is truly multi-faith. Beyond syncretism, there is a loss of religious boundaries: I have conducted worship including Holy Communion which has included Roman Catholics, pagans, Muslims and atheists all open to finding 'something' because others do. We have people of all religions (including Jedi), many of vague eclectic beliefs, and a fair few confirmed atheists. I have used Wesley's assertion that Communion is a 'Converting Ordinance' as validation for offering the elements to 'whosoever will'. In my heart, though, I think I rely less on the theology than my conviction that a truly loving God would not turn away those who are already so excluded, devalued and 'poor'. This is an approach that would perhaps be challenging for those whose sacramental theology contains and element of guardianship.

There may be long debates. Occasionally people will avoid those whose belief structure is antithetical. But mostly there is tolerance and a willingness to live together on the basis of “What works for you”. If someone is being overly evangelical about their beliefs the staff will step in. (And if the staff are, the chaplain will step in!)

Just as the community is open to people of all beliefs, so it is accepting of almost all possible variations. There is little racism, sexism, disablism... on the whole the community is non-judgemental. People are allowed and encouraged to be themselves, anger and frustration can be expressed. There is no obligation to be 'nice'. If you are having a bad day, it is acceptable to say so in whatever terms are available.

The lack of judgement extends to people outside the law. There are people with drug addictions, petty crime convictions, and those who have spent time in either prison or a secure unit whose crimes are not spoken of. They too are part of the community and accepted members.

The community shares in a common understanding that to have a mental health problem is to be excluded, stigmatised and often to find yourself at the very bottom of society, in the worst housing, with little hope. People can be taken from their homes and forced to stay against their will in hospital, forcibly medicated and restrained (though the staff try their best to diffuse problems long before they get to that stage.) This place of exclusion puts them in a special place on the edge of our society. To be their chaplain is to share that liminal place on the edge.

The job of being its chaplain

As chaplain working in the NHS, I am employed by a secular agency to proved for the spiritual and pastoral needs of all service users, their carers and families, and the staff regardless of religious affiliation. I work with people of all religions and of none - people who are vulnerable and often hurting. Whatever my own beliefs, it is not my job to impose my beliefs or suggest that people change their religious beliefs. Were I to try to 'evangelise' I would be removed from post. I am required to respect and support people's religious beliefs, and help them to find spiritual answers that work for them in their context, rather than try to convert them to mine. This I cannot express to firmly: I am not an evangelist.

This does not mean I conceal or deny my own beliefs and religious background. On the contrary, honesty and integrity are essential when dealing with a group who are well skilled at detecting anyone and anyone phony.

One of the essentials of my job is offering hope. Whether that is existential hope of a better eternity or simply hope that one's illness may improve a little – I am a pedlar of hope. Sometimes holding on to hope for someone when they have no hope for themselves can be helpful.

In order to do this, I need to be alongside people. I often talk of sitting with people at the roadside on their journey of life, and sometimes we play metaphorical noughts and crosses in the roadside dust till they feel ready to go on. Being present, unafraid of another's pain, grief or disturbance and staying there is vital. Many healthcare professionals are uncomfortable with pain, and want to rush people through into distraction or quick recovery. Both have their place, but sometimes pain has to be sat with: grief takes its own time, whether for a loved one, a way of life or a self-image that no longer fits.

One of the things that I can usefully do is allow people to talk about 'non-ordinary experiences'. I have lost count of the number of times someone has asked “Can I tell you something in confidence” only then to share a simple story that might fit well into anyone's testimony or witness. The story ends with “I can't tell anyone else – they'd increase my meds”. That the system has a person who stands for a recognition that there is mystery in life, that the non-ordinary happens, that not everything that doesn't quite fit has to be defined as madness, is a certain reassurance. And sometimes working on the bridge between mental health and spirituality I see things that in fact work the other way: I recall a nurse asking me to speak with a patient who was afraid of going to sleep because of a fear of death. A short conversation revealed that the patient was no more (or less) afraid of death than most – but was experiencing a sensation like 'dying' as a result of particular sleeping tablets every night.

Perhaps the most useful thing I offer is that the chaplain, drawing on the Methodist concept of ordination as conferring the status of 'representative person' is to stand somehow as representative of some mysterious divine power which loves people. Many people who have mental health problems find themselves there as a result of unhealthy relationships in their formative years: put simply, they have never known unconditional love. While I don't claim to be the super-human, capable of loving unconditionally, I try hard to offer my patients steadfastness, consistency and compassion. I don't always succeed. But I believe my ultimate vocation is simply to love people. This for me is far more important than the language I use. Indeed for many of my patients it would be inappropriate to use 'the God words'.

I am also chaplain to the institution. Our departmental budget is small but the simple fact that the NHS, operating as it does on a predominantly medical model, employs chaplains makes a statement that there is more to being human than can be reduced to chemicals and behaviours. The Trust makes a (small) space for mystery, for the non-ordinary, for that aspect of humanity which we describe with the umbrella term 'spirituality'. And as an NHS employee, it is sometimes my job as chaplain to speak prophetically to the institution when it is being abusive or coercive.

The challenges

The first challenge to this work is simply taking emotional care of myself. Ignatius Loyola's prayer may be a wonderful goal, but frankly if I were to fight and not head the wounds, labour and not seek for rest, I would very quickly become exhausted and burned out. At which point I am no use to anyone, and would be letting down my clients.

Coming from a church background that assumed we could work all hours except one hour per day, one day per week and 3 days per quarter, plus 5 weeks per year leave (that's what CPD said when I started) I confess I still struggle to feel 'good' about such self indulgence as legitimate time off. I

believe this is something which chaplaincy can return to the churches: there is little of value in working your staff to the point of breakdown. Everyone needs a Sabbath. (Exodus 20:8-11)

In addition, the NHS requires all staff who have client-facing contact to engage in clinical supervision. I also arranged for myself to have theological reflection space with colleagues and with a skilled theologian locally. I often wonder how much 'supervision' and reflection space my colleagues in circuit get: I know I had to arrange it for myself when I was in circuit. Along with ensuring rest, proper space to reflect, share and do theology should be offered for everyone who is engaged in pastoral work.

Another challenge early on was to my understanding of reality. Most of us live in 'consensus reality'. The steady growth of popular scientism (not science itself) has left those of us who have religious or spiritual belief as a tolerated minority, though increasingly that tolerance is being eroded, not least because of a rejection of religious extremism. How do I respond to someone whose experience of reality is completely unique?

If the person is also incoherent, unable to manage the basic requirements of their life then it might be easy to dismiss their experiences as 'psychotic'. But many such people are otherwise calm, capable people: at what point does diverse belief and life experience move from 'legitimate difference' into 'madness'? My own experience of reality is challenged by the company of people who experience life in ways I cannot imagine. Exactly what is 'real'? Within the religious community we live with people who have non-ordinary experiences which are inward, personal and not subject to verification: does that give us a unique insight into people who hear voices or see visions which others do not? How many people who today are deemed mentally ill would once have been deemed religious fanatics or even saints? Would some of the saints have been detained and medicated if judged by today's standards? How exactly do I decide what I believe to be real?

If I'm honest, I find that this is one of the places where 'not having to decide' is useful. I can live with the uncertainty, the questions, the openness to possibility that some things might be true – but I don't need to decide. I can even live with possibilities which are paradoxical or even irreconcilable: I don't need to know whether fairies/angels/unicorns... exist. Or don't.

Some have tried to make a clear distinction between 'spiritual experience' and 'psychosis'. My personal approach is that psychosis is better interpreted as an excess of spiritual experience – as if the identity 'blows a fuse' from too much exposure to the Holy. If this is so it would account for why so much psychotic experience is couched in religious language. It also challenges us in how we respond to people experiencing psychosis: it has been argued that the recovery journey is shaped by how the community responds. In some societies, the 'mad' individual is considered holy, set aside, touched by God. Their unusual behaviour is accepted and explained. They are valued and allowed to move back to more 'normal' behaviours in their own time. In Britain today, that same person is stigmatised, confined, medicated whether or not they want it, and forced to conform. Can we as a church community be brave enough to speak on behalf of those who are experiencing reality in ways outside the accepted norms? How far can we brave if their resultant behaviour is unusual?

Given the levels of suffering experienced by those with mental health issues, and their loved ones, I am sometimes faced with heard questions of theodicy. How can a loving God allow the human mind to be so breakable? How can He allow the levels of abuse that lead to such mental torment? How can he allow the breakdown of mind that results from dementia?

There are no easy answers to these questions. Indeed, one might argue there are no answers, easy or not. Most attempts to answer questions of theodicy serve to salve the conscience of the answerer rather than assist the questioner, and many end up making the sufferer feel worse. John Swinton writes movingly on this in 'Raging with Compassion'. Sometimes the most helpful thing is to cry with the hurt, rather than trying to justify the unjustifiable. To quote from Timothy Rees's hymn “And when human hearts are breaking under sorrow's iron rod, then they find that self-same aching deep within the heart of God”. But even this is not really an answer.

Another challenge is that of the nature of human evil: working with so diverse a group, I can often find myself trying to get alongside people who are both harmed and harmers. Many of our service users can tell horrific stories of abuse, particularly from childhood. I often find myself wishing I were capable of time travel and could change the past.

However, the forensic element of work means I am also required to be chaplain to those who have perpetrated crimes against others. This is challenging in a different way. How am I to respond to the call to offer love and acceptance to people who have committed offences against others? Especially when I know too well how damaging their actions may have been to their victims.

But there is not only the personal challenge: the theological challenge stands. Is there a limit to the love of God I should be offering?

The question is not a simple one, embracing issues of the need for repentance (which may not be possible for someone deeply disturbed), the need for understanding the background (most abusers have themselves walked paths of tremendous pain) and the simple question: does God have a set requirement before offering love? Or does God love first, and worry about repentance and change afterwards? (1 John 4:10)

And on the other hand, I meet many people who are convinced that God cannot possibly forgive them for some sin, real or imagined. Often these people believe they have committed “the unforgivable sin” (however you interpret Mark 3:28). In most cases the reality is that they cannot forgive themselves. Many of the people I work among carry a deep sense of self-hatred, a deep belief that they are somehow unacceptable.

How does the church address people who believe themselves unacceptable to God? This requires the exact opposite of traditional evangelical preaching where one is trying to 'convict people of their sin'. These people are all to aware of their imperfection: they believe they are quite beyond redemption. To us, that might seem folly: surely an omnipotent God can forgive? But these people are caught in something like an inverse grandiosity – they believe they are SO awful.

John Wesley's “Four Alls” are a reassurance to me here. All can be saved to the uttermost – no-one can fall out of the reach of God. I often use Romans 8: 39 “Nothing in all creation will be able to separate us from the love of God in Christ Jesus our Lord”. Even more than what I say, I need to show that no-one is beyond acceptance – and that can be really hard!

Sometimes I find myself feeling deeply angry at the harm done to a patient. This can be difficult to manage. We are taught that anger is somehow 'unacceptable'. Patients who have been abused over long periods have often rationalised the abuse by believing they deserved it or did something to provoke it. Their abusers may have encouraged this belief, Many have been taught that to be 'acceptable' they must endure without complaint. For some, to hear someone else express righteous

anger on their behalf can be the beginning of a realisation that what has been done to them has been wrong. Helping people to express their anger hardly sounds like a ministry – but it can be a vital part of what I do.

Many people ask me what happens to those who commit suicide. This often comes from a profound desire for death and will to suicide. People who consider themselves unfit to live, those who believe they are a burden to others and those who find their emotional pain too hard to bear and seek escape and peace can all experience strong suicidal desires.

I am sure my secular colleagues would want me to tell people that suicides go to hell as that might reduce the risk of them committing suicide. Certainly the church has historically held the position that suicides, in rejecting life, are rejecting God and therefore placing themselves beyond his reach.

My own belief is that if I can understand how someone can feel that desperate, then surely God can. I cannot believe that God could condemn people for an act born of anguish and despair.

Suicide is one of the extremes of mental ill-health that is used to separate people from responsibility for themselves. Someone with a mental health problem can be confined, medicated, deprived of their property, required to engage in therapy, even restrained on the grounds that it is 'for their own good'. In doing this we raise serious questions about the autonomy of the individual and their right to self-determination. If someone truly wishes to end their life, and has done so for a suitable length of time, have we the right to prevent them? In confining someone, we give them less reason to live rather than more. However, to allow someone to harm themselves opens the institution and the staff to accusations of neglect and culpability. How far should we go in preventing someone from doing what they wish with their own life? How long can we require someone to live in mental torment because we judge them too unwell to make a decision for themselves? Suicide is often seen as “a permanent solution to a temporary problem” - but what of the person whose mental torment is permanent?

This is a challenging question for the chaplain: I do not believe that death is the worst that can happen to someone. Even St Paul wished he could die for his own benefit, and only wished to live for the sake of others (Phil 1:23-24) Being able to reassure someone that wishing to die and contemplating it is not a crime in itself – after all St Paul did it – can be a way of opening a door to other possibilities.

One of the big areas of my work is working with people who are struggling to manage loss and bereavement. Over the last century Britain have moved from a society where death was almost ever present, where every family had experienced infant mortality and where death took place in the home to one where death is excluded, eliminated from discussion and feared. Along with that, people are less able to manage other forms of grief or bereavement. Increasingly people have little or no religious belief to offer them hope of something beyond this life.

When someone already has a mental health problem, managing bereavement can be an extra challenge too many. Indeed, for many people failing to get through the grief process can be their mental health problem.

Helping people to understand that it's ok for grief to hurt – indeed quite normal, even after a long

period of time – is the first thing I can offer. Jesus wept at the death of his friend, and promised comfort for those who mourn. What sort of people would we be if we did not mourn? One only mourns that which one loves. I need a willingness to sit with and stay with the pain. Sometimes I help people create personal rituals which express their own beliefs or those of the person they've lost. This can be especially valuable in dealing with other forms of bereavement – loss of job, home, marriage, even one's self-identity. In this, my work is not so different from that of a circuit minister, although the majority of people do not have connections to formal religion.

How does the church respond to this community?

Over the years I have heard stories of deep pain caused by the church.

Some of the people I work with have experienced abuse that was inextricably bound up with formal religion. Sometimes abuse has been from a person who was in a place of authority in church or a person who claimed the authority of church or scripture for their dominant and dominating position. We have all heard the terrible stories of abuse perpetrated by clergy of other denominations – Methodism is not exempt. We need to be prepared to hear these stories and take them seriously.

For some, the result will be rejection of God – or even a deep hatred of a God they cannot quite reject. For these people, being allowed space to be angry at God as they understand him can be essential. I even need sometimes to give them permission to reject God – because only in rejecting and letting go of our imperfect images of God can we be free to find more wholesome and holy ones. This is true for all of us in our on-going relationship with the Holy, but most marked in those whose concept of God is so destructive.

I have met people who have been demonised, excluded and even physically injured because they could or would not conform to an accepted pattern of behaviour or belief system. The church can be a place which has very rigid and strict requirements of behavioural conformity.

I can also recount many stories of people who have been hurt by being told that they are somehow unacceptable to God. Their sexuality, philosophy or questioning has placed them outside the boundaries of what is deemed acceptable.

Another approach which is deeply unhealthy for people with a mental health problem is the prosperity gospel, or its weaker forms which suggest that illness is a result of some unconfessed sin or fault. Telling someone who is suffering profoundly (often as a result of something done to them by others long ago) that it is somehow their own fault or weakness compounds the problem.

One of the things which people are often encouraged to do is forgive abusers. While this may be an ultimate goal, I find many church people can offer this as a glib solution far too quickly. For someone who has been told for much of their lives that they 'deserved' to be abused, that it was their fault, it is important first to be allowed to be angry for only in anger can they understand their own value. To be instructed to forgive too quickly (and made to feel guilty if one cannot) can feel as if the person is again being negated and their suffering disregarded. In extreme cases it can be as emotionally destructive as the initial abuse. I always tell people that I do not encourage forgiveness until someone has first been truly angry – reaching an anger that understands that abuse is monstrous – even if it was perpetrated against oneself (no sense of “It was only me, so it didn't matter”). True forgiveness can only happen when the enormity of the crime is appreciated. In this the paradox of the wrath of God and the love of God is a helpful model: God can forgive because

God truly understands how destructive sin is.

I would, however, not want people to think that all contact with the church and the gospel is destructive to people who have a mental illness. Those churches which endeavour to offer a truly open and welcoming community are wholesome places – even if they fail occasionally. Good pastoral care can be a tremendous resource for people. A church which is willing to allow people to ask their questions, bring their gifts and find a place can be a truly healing community.

The gospel of a God who accepts and loves, even if no-one else does, can be received as truly liberating and healing. For people who have come to believe they are unlovable, the promise that God does love them holds the chance of hope and self-acceptance, difficult though this is for many.

Some Questions to ponder

A young woman who has a history of abuse from males tells you she believes she is lesbian and fears she will go to hell: what do you say to her?

A young man has suffered a breakdown after being arrested for having images of child abuse on his computer. He fears his future will be jail, loss of his job and homelessness. He hates himself for what he has done: how do you respond?

A young woman hears voices telling her she is utterly worthless and deserves to die. She suspects they are divine voices judging her. She wishes to kill herself in response: How can you help?

An older man tells you he has just been diagnosed with dementia. He is afraid of what will happen, and asks who he will be when his memory is gone: what do you say?

A man has told you earlier in the week that he does not believe in God. He attends your weekly communion service and holds out his hands for the elements: what do you do?

A woman shares with you that she has seen God and the devil, and regularly talks with angels. She also speaks of having stroked unicorns. How do you feel?