Long Coats, Short Coats and No Coats: Chaplaincy presents to Psychiatry at The University of Texas MD Anderson Cancer Center, a report

David K. Stouter, M.Div, BCC
Chaplain
Department of Pastoral Chaplaincy & Pastoral Education
University of Texas
M. D. Anderson Cancer Center
Houston, Texas

AnneMarie Wallace, BS
First Presbyterian Church
Houston, Texas

James Duffy, MD
Sierra Tucson treatment Center
Tucson, AZ

Anis Rashid, MD
Department of Psychiatry
University of Texas
M. D. Anderson Cancer Center
Houston, Texas

Alan Valentine, MD
Chairman, Department of Psychiatry
University of Texas
M. D. Anderson Cancer Center
Houston, Texas

Correspondence may be sent to: David K. Stouter, e-mail: dkstoute@mdanderson.org

When Chaplaincy and Psychiatry examine their own methodologies, do they work to reduce age-old barriers, thereby involving each other to promote holistic patient care? Chaplaincy trains in self-awareness and pastoral care specializing in religion, spirituality, grief and loss; while Psychiatry trains in medicine, neurology, and the behavioral neurosciences. Relationships across disciplines with common interests are vital. Ongoing dialogue between these professions will enhance the shared goals of coping and healing in the communities they serve.

The invitation to present the work of chaplains to members of the Department of Psychiatry was exciting. Staff Chaplain David Stouter and AnneMarie Wallace, Manager of Clinical Chaplaincy Programs, had given prior in service presentations regarding chaplaincy to other departments, to acquaint them with services provided by the Department of Chaplaincy and Pastoral Education at The University of Texas M.D. Anderson Cancer Center. This presentation focused on the breadth of pastoral services; it incorporated elements of common ground with the psychiatric team. The invitation represents one example of a number collaborative experiences that have taken place between pastoral care and other disciplines, including psychiatry, in other healthcare settings. This report serves as an illustration of the kind of events that continue to be mutually beneficial.

Historically the relationship between psychiatry and religion, hence chaplaincy, has been strained: “The relationship between psychiatry and religion is complex, and has been complicated by the heterogeneity of each.” (Blass, 2001). Both psychiatry and religion share complexity in professional self-understanding as well as in an understanding of each other’s definitions and roles. We wished to offer a model to facilitate greater interaction between psychiatry and chaplaincy in contemporary health care. Psychiatry’s invitation demonstrated a desire for greater understanding between these two departments at the M.D. Anderson Cancer Center.

The presentation’s first slide looked like a Houston summer rain, showering upon leaves lying on the ground. In the forefront were highlighted words of a poem whose sentiments all could appreciate:

> *The rain to the wind said, “You push and I’ll pelt.” They so smote the garden bed that the flowers actually knelt. And lay lodged - though not dead. I know how the flowers felt.* Robert Frost (1929)

This poem served to highlight a familiar experience encountered daily in our shared work. Heads nodded in agreement. All of us had experienced grief and loss. Most of us shared an empathic capacity that grew out of similar feelings of grief and loss. Establishing such a commonality –- a level of shared life and empathy by psychiatrists and chaplains — proved to be an important way to begin this session.

Despite the separate and unique paths and training models, identifying these connections helped to establish a common understanding. Most attendees acknowledged the safety they felt in this session that afforded the opportunity for discussion. Jennings (1990) observed:

> If dialogue between theology and the human sciences is to be fruitful it should also be directed toward a common subject matter. The subject matter common to both is not the existence or nature of God but the nature and possible transformation of human existence. Too often dialogue is blocked by excessive preoccupation with the categories of the theism-atheism debate. This preoccupation may prevent the discovery of important areas of shared interest and possibly fruitful discussion. (p.864)

Many spiritual caregivers are familiar with Frederick Beuchner’s (1973) observation that “the place God calls you to is the place where your deep gladness and the world’s deep hunger meet.” During the presentation Dr. Jim Duffy noted: “In order to become a healer, we must move beyond the mechanics of mastery to become journeymen [women] of the suffering of the world.”

That day the room was filled with the faculty, fellows, and residents, and advanced practice nurses clad in the long white coats, medical students in short white coats, and chaplains in no coats. The visual representation of the white coats and no coats depicted the separate approaches and orientations. However, all gathered on a common journey, to find commonalities and achieve a fuller understanding of the work of chaplains. A description of chaplaincy and the many services it offers to patients and family/caregivers within the context and operations of M.D. Anderson became a significant component of the presentation. The question, “Just what does a chaplain do?” was not unique to our setting. Therefore, Stouter and Wallace attempted to situate spiritual care within the academic health care environment. The M.D. Anderson Cancer Center resides within the Texas Medical Center. In such an academic environment it seemed important to explain how chaplains are trained. Answers included such fundamentals as the existence of ACPE and CPSP as nationally accredited educational programs that are endorsed by many chaplaincy board certifying cognate groups. As an example from our setting, we noted that the ACPE training model is used at MD

Anderson. Many of the program's graduates have pursued board certification by the Association of Professional Chaplains. One psychiatry faculty member observed that he did not know "that chaplains had that much training." We noted a keen interest among our audience in the chaplain's training and commitment to provide spiritual care with diversity in mind. Even though chaplains have specific faith/spiritual training and commitments that they are trained to work with patients and families who may not share those same commitments (Mohrman, 2008, p.5) struck a receptive cord. We noted that like other health care professions, chaplains make referrals when something is beyond their own professional training and/or spiritual competency. The psychiatry faculty at M.D. Anderson is spiritually and culturally diverse, and all acknowledged the importance of this expansive approach. Both disciplines are aware of these diversities and are actively identifying ways to incorporate these nuances in their patient care models.

We identified the work of Dr. Helen Rose Ebaugh, Professor of Sociology at the University of Houston. We cited Dr. Ebaugh's lecture, "Religion and Immigrants in Houston: Interfaith Opportunities & Challenges," (May 1, 2008), at Rice University's Boniuk Center for Religious Tolerance. She took the audience through her extensive studies on cultural and religious diversity and the challenges immigrants face regarding spiritual adaptation within a new culture. Dr. Ebaugh's research found that persons become part of a "subculture" within their inherited religious culture, and are often misunderstood by it. Similarly, the religions of many immigrants constitute minority religions in the United States that are often ignored or misrepresented by the dominant Christian culture. The ensuing discussion highlighted the chaplain's ever-present pursuit of achieving broader knowledge about the varieties in personal spirituality and in recognizing that a lack of awareness could exacerbate spiritual suffering. Some of the faculty present expressed their own experiences with the conflict between affirmation of personal heritage and the subtle adaptations made along the way in assimilating into an adopted culture. The chaplains offered quotes and images from various spiritual-cultural traditions as a way to illustrate the importance of sensitivity to other belief systems. Two examples were cited from African traditions (Follini & Follini, 2005) to emphasize the kind of listening both disciplines could employ:

> We are about to go on a journey into an 'underground' world, the world of meanings hidden beneath the appearance of things, the world of symbols where everything is significant, where everything speaks to those who can hear.
>
> *Peul oral tradition*

and,

> Words have an intrinsic power…when they are true. Sensible and sincere, they heal "the hearts that mourn…" They help to…relieve suffering. Words are sacred.
>
> *Aminata Traoré*

As Ellen Faubert's remarks at the 2009 Spiritual Collaborative Summit emphasize,

> This collaboration between psychiatrist and chaplain may bring new depths to the meaning of holistic patient care of body, mind and spirit. Let us bring that integral part of recovery to our patients, who desperately want to be treated as whole human beings – who want to talk about the very depths of their soul, and their spirit (February 2, 2009)

In sum, long coats, short coats and no coats gathered to learn and share. We were invited back to continue the discussion of enhancing the collaboration between chaplaincy and psychiatry. Trust is built one relationship and opportunity at a time. David Blass (2001) suggested a conceptual framework for the interaction between psychiatry and religion; especially promising was in assessment and patient care: "An approach to the relationship that is fueled predominantly by clinical rather than

theoretical concerns can help maintain the interface in constructive terms, grounded in mutual respect and the search for truth … both fields will thus be enriched in their quests to improve the lives of people and plumb the various mysteries of existence." (Blass, p. 83)

A text on clinical practice guidelines (Clinical Practice Guidelines in Oncology, Distress Management, 2007) provides examples of ways in which the two disciplines collaborate. In particular, the cooperative efforts of psychiatry and chaplaincy render pathways for pastoral interventions when there is evidence of grief as well as concerns about death and afterlife, conflicted or challenged belief systems, loss of faith, concerns with meaning/purpose of life, concerns about relationship with deity, isolation from religious community, guilt, hopelessness, conflict between religious beliefs and recommended treatments, and ritual needs. Action and decision flow charts show the various points mental health professionals and chaplains work together in assessment and care delivery.

Following are comments offered by three physicians attending this presentation:

Alan Valentine, M.D.

> *During the time of my residency training (the late 1980s), the issue as presented was not so much one of hostility toward chaplaincy, as it was the need to maintain distinct boundaries. Appropriate roles, the dangers of self-disclosure, and the motives of psychiatrist and patient regarding discussion of belief systems were to be seriously considered. Later on this did lead to problems in the care of cancer patients, especially those who were definitely suffering but did not quite fit DSM diagnostic criteria. The boundaries could be indistinct and it could be (and sometimes still is) difficult to tell when the issue in question had "crossed the line" and it was time to refer. I gradually, and with some missteps, learned that it is helpful — even necessary — to try to understand a patient's religious or spiritual belief systems as a function of his or her ability to cope with illness, and that anxiety and depression can deprive a patient of access to spiritual support. Still, there is the issue of roles. My guess is that well-trained chaplains can function effectively as psychotherapists much more easily and appropriately than psychiatrists can or should function as chaplains.*

Anis Rashid, M.D.

> *Many years ago during my training, I had little knowledge and understanding of the role that chaplains play in a hospital setting. We had no interaction with them and would hardly see them. The entire picture has changed in the past few years when we see chaplains side by side with other services deeply involved in patient care. This takes me back to one of my patients who would have benefited tremendously from their services. Mr. D was a 27-year-old gay man with newly diagnosed testicular cancer. He was extremely depressed and tearful during the interview. Multiple times he blamed himself for everything that went wrong and sounded as if the cancer diagnosis is his fault. Multiple visits, antidepressant medications and sleep medications did help some, but he was not at ease, constantly blaming himself and at times very anxious and angry. One afternoon he opened up and said he was nervous as he was going to die soon and would go to hell because of his sins. Homosexuality was not acceptable in his faith tradition. He had conflicts in his mind with very deep wrongdoing within the sphere of his beliefs and needed help to reconcile the differences. If it had been available then, I*

would have referred him to Chaplaincy services. Now I see the value and importance of integrating Chaplaincy with Psychiatry to provide holistic care to the person as a whole. Patients diagnosed with cancer undergo severe emotional, physical, social and spiritual distress. Sometimes their faith starts shaking. Care must be provided to the patient as a whole person. These patients need support not only from mental health providers, but also from a spiritual person as part of the total holistic care. In our practice we often see that the cancer diagnosis brings up feelings of guilt and shame from the past. Inner healing of these patients does not start until the pain and suffering is treated. Here we share the common ground with Chaplaincy. The focus is to treat the suffering and bring relief, whether it is psychological or spiritual in nature. Working side by side, within boundaries and respecting each other's area of expertise, Psychiatry and Chaplaincy may be able to provide total care of the patient.

James Duffy, M.D.

I am delighted and sad to write a commentary on this wonderful article. I am sad because the article (despite its optimistic tone) describes the great professional cavern that has come to divide our work as healers. It seems sometimes that our need to deconstruct the suffering of our patients into its "bio-psycho-socio-spiritual" components has been driven more by professional agendas than humanistic ones. Before the ascent of allopathic scientific medicine, there was a time when the healer's work inhabited the terrain of both the soul and the body. A time when healing was considered to be as much a spiritual process as a physiological response. A time when the physician-priest was as comfortable resting in the uncertainty of the questions as he was in the certitude of science. I am delighted by this article because it reminds me that there is a way home to healing. Although our world seems to have become so much more complicated and the walls between our professions have become so much higher, it is clear that we all share a common bond – to create a more compassionate world where healing can be more than just mere mechanics. To construct a model of healing that understands that healing comes from our experience of making connection to a higher meaning – that understands that healing begins presence and our experience of an authentic healing relationship. I am honored to work along side my chaplaincy colleagues for they are willing to travel with our patients to places that I am not equipped to explore. I hope over time that that the conversations between chaplains and physicians will grow and that my fellow physicians will have the humility to recognize how much their patients and they can benefit from their wisdom and the deeper healing they promote. We can never turn back history; however, I hope that one day we will find our way through to a model of healing that utilizes the richness of both professions.

In closing, Stouter and Wallace noted that cultural competence requirements for all health care institutions and practitioners are important, generating greater collaboration between different disciplines. Both psychiatry and chaplaincy are committed to this task to fulfill their mandate to provide care for people in time of need. As Curlin notes "…the new legitimacy of religion and spirituality within the profession is perhaps most clearly indicated by the 1995-1996 edition of the *Graduate Medical Education Directory*, which

required psychiatric residencies to include didactic sessions on issues of religion and spirituality." (Curlin, et al. 2007) Since psychiatrists frequently have conversations with patients in these areas, broader training is both indicated and mandated. Thus:

> Patients may increasingly have the opportunity to discuss spiritual/religious concerns with their psychiatrists. Since religious patients may benefit from treatments that accommodate their religious beliefs, outcomes could improve for this group. Improved outcomes, however, may depend upon knowledge and expertise that psychiatrists bring to such discussions. …Because religion/spirituality is an important component of many clinical encounters, psychiatrists would benefit from increased professional training on religious/spiritual issues as well as increased awareness of pastoral or theologically trained colleagues with whom they might consult when appropriate." (Curlin, p.1830)

Professional associations certifying chaplain competency stipulate that cultural competency is one requirement for board certification. Sensitivity to and clinical competence in managing the varieties of psycho/social/spiritual cultures remains an ongoing task. As advances in health care continue the conversations like those described here will be paramount for the holistic care of the person.

References

Blass, D. (2001). A conceptual framework for integration between psychiatry and religion. *International Review of Psychiatry*, 13, 70-85

Buechner, F. (1973). *Wishful Thinking: a Theological ABC for Seekers.* New York: HarperCollins

Curlin, F.A., Odell, S.V., Lawrence, R.E., Chin, M.H., Lantos, J.D., Meador, K.G., et al. (2007) The relationship between psychiatry and religion among U.S. physicians. *Psychiatric Services*, 58, 1193-1198

Curlin, F.A., Ryan, L., Odell, S., Chin, M.H., Lantos, J.D., Koenig, H.G., et al. (2007). Religion, spirituality and medicine: psychiatrists' and other physicians' differing observations, interpretations and clinical approaches. *American Journal of Psychiatry*, 164, 1825-1831

Ebaugh, H. R. (lecture, May 1, 2008) Religion and immigrants in Houston: opportunities and challenges. Rice University Boniuk Center for Religious Tolerance, Houston, TX

Faubert, E. M. (2009, February). Do psychiatrists hold similar views towards spiritual or religious beliefs as Dr. Freud?: how to build relationship and collaboration between psychiatrists and spiritual care providers. Paper presented at Spiritual Care collaborative, Orlando, FL

Follini, D.& Follini, O. (2005). *Origins: African Wisdom for Everyday* (G. Edwards, Trans.) New York: Harry N. Abrams

Frost, R (1929). Lodged, In *West – Running Brook,* New York, Henry Holt

Jennings, T.W., Jr. (1990). Pastoral Theological Methodology. In R.J. Hunter (Ed.), *Dictionary of Pastoral Care and Counseling*, (p.864), Nashville, TN: Abingdon

Mohrman, M.E. (2008). Ethical grounding for a profession of hospital chaplaincy. *The Hastings Center Report,* 38, 4-9

National comprehensive Cancer Network (2007). Distress management, In *Clinical Practice Guidelines in Oncology* (version 1)