Some Problems and Ethical Questions Concerning Pastoral Care of Mentally Ill Persons

Miroslav Škoda

Pastoral care of mentally ill persons is becoming a pressing issue especially because the number of mentally ill persons keeps rising.[1] The pastoral care in question has its specific characteristics, problems and ethical questions arising mainly in connection with solving these problems. In the present paper we want to focus on those which in our view substantially affect the quality of pastoral care of mentally ill persons. These are on the one hand negative prejudices with respect to mentally ill persons widespread in society (the parish) (prejudices with respect to their stay in a mental hospital, with respect to psychopharmacological medication and others). On the other hand it is in some cases a problem of the pastoral worker who does not, or simply cannot, have enough necessary information on the nature of the psychological ailments of the mentally ill person or the history of his spiritual life. This deficiency impedes spiritual accompaniment and helping the mentally ill person in his difficulties.

To reflect the above mentioned problems and search for answers to increasing the quality of work in this field of pastoral care it is first necessary to define the (basic) concepts relevant to our intention, especially whom we classify among the so-called mentally ill persons and who is a pastoral worker. On the grounds of this distinction we can then specify the level of our focus problems and the related ethical questions. This paper intends, at least at the general level, to show the importance of not only the professional, but also the ethical competency of the pastoral worker, so that his ministry to the mentally ill is erudite and ethically justifiable.

1. Mental illness – mentally ill person – prejudices

The concept of mental illness is not easy to define. The concept of illness is often presented in contrast to the concepts 'normality' and 'health', where normality is taken to mean phenomena found in most people of a given cultural sphere. Accordingly, health is a specific case of the normal and has an objective and a subjective aspect.[2]

Sociology sometimes understands illness as a specific deviation. Unlike social deviations it is not followed by negative sanctions, because it differs from them by the criterion of personal responsibility. An illness appears without the ill person's volitional contribution. In this context the role of the ill person is described by T. Parson (1965) and elaborated by E. Freidson (1970), with emphasis on four features: "First, the ill person is considered not to be responsible for the origination of his state and not to be capable of removing it with his will. Second, he is

1 In 2012 there were 578 413 persons in ambulatory care (556 456 persons in 2011) and there were 40 683 patients in psychiatric hospitals (40 754 in 2011, but 39 697 in 2010). In 2012 the total number of 2 833 944 psychiatric examinations were carried out (2 799 199 examinations in 2011). The individual indices thus show an increase of 4% in the number of persons cared for in ambulatory care, a decrease of 0.2% in the number of patients in psychiatric hospitals and an increase of 1.2 % in the number of all psychiatric examinations in 2012 as compared to 2011. According to © ÚZIS ČR, 2012, Zdravotnická ročenka ČR 2012 (on-line), at http://www.uzis.cz/katalog/rocenky/zdravotnicka-rocenka-ceske-republiky, retrieved 17 March 2014 and according to © ÚZIS ČR, 2012, Zdravotnická ročenka ČR 2011 (on-line), at http://www.uzis.cz/katalog/rocenky/zdravotnicka-rocenka-ceske-republiky, retrieved 17 March 2014.

2 Cf. Karel DUŠEK – Alena VEČEŘOVÁ-PROCHÁZKOVÁ, *Diagnostika a terapie duševních poruch.* Praha: Grada Publishing, 2010, pp. 22–23.

absolved from his duties so far. Third, the ill person is obliged to evince awareness of the undesirability of his state and its impermanence, and finally (fourth), he is obliged to search out professionals and cooperate with them, unless a spontaneous adjustment occurs." [3]

The specific position of illness with respect to social deviations formulated by sociology prefigures the specific position of mental illness within the concept of illness. While "in the case of somatic illness we have to do with disorders of structure and function of organs, (…) in the case of mental illness (with the exception of organic ones, of course) we are dealing with nothing of the kind."[4] It is therefore difficult to stipulate what is a mental illness and what method can be employed to diagnose it. Alberto Bondolfi notes in this context: "The only thing we can agree on is that there can be a mental illness where there are no demonstrable organic causes, and that mental disorders or mental illness have various forms and degrees, which it is very difficult to distinguish."[5]

It is ultimately precisely this conception of illness as a social category what makes it possible to include mental disorders in the International Classification of Diseases (further ICD). This social category is "intended to designate the state of individuals, of which the given society presumes that it disables the bearer from fulfilling his usual roles, and which he cannot remove by mere willing."[6] ICD is then "a list of states sharing the above assumptions."[7]

The difficulties with defining mental illness, i.e., the state of a mentally ill person, outlined above ultimately reflect the problems in the very assumptions of pastoral practice with mentally ill persons and predict the numerous pitfalls it involves (see below). A problem is presented e.g. by persons who in fact suffer of a mental illness but do not seek professional help. No one has determined their diagnosis. This group of mentally ill persons may present great risk to society. Frequently such persons are dangerous to themselves as well, e.g. by self-mutilation or suicidal acts. The reason why they do not seek the help of a psychiatrist or psychologist often is precisely the socially widespread prejudice against this procedure. A mental illness still tends to be considered shameful. In many cases it is socially more acceptable to undergo abortion than visit a psychiatrist. This deep deformation makes the situation hard not only for the ill person himself, but especially for his closest family and friends. Christians also have unjustifiable "religious" prejudices in this respect. Among these there is e.g. the conviction that one is responsible for most kinds of mental ailments. On this view mental illness is a result of moral failure or insufficiently lived faith. Even the use of psychopharmacological medication is on this view against sound faith.[8] These prejudices are without doubt at odds with the conception of the social role of a patient, i.e., with its four characteristic features described above.

In practice there also occurs a problem inverse to the one we have described so far. The diagnosis of mental illness may be applied even to those who need not in fact be mentally ill. This may be due to a falsely determined diagnosis on the part of the doctor, which may be the result of purposeful behavior (simulation, aggravation) on the part of the "patient". Thus we can

3 Karel CHROMÝ, *Duševní nemoc. Sociologický a sociálněpsychologický pohled.* Praha: Avicenum, 1990, pp. 15–16.

4 Ibid., p. 19. Author's note: The development of medical science in the field of diagnostics shows that a great number of mental disorders is of organic origin. It need not be a case of disorder of an organ as a whole. At the molecular level various roles are played by genetic dispositions, biochemical processes, neurobiological phenomena and neurotransmitted information and others.

5 Alberto BONDOLFI, Ethische Wertungen des Suizids im Laufe der Geschichte: Übertretung des Tötungverbots, Pathologie…? In: *Suizid...? Aus dem Schatten eines Tabus*, ed. Hans-Balz PETER – Pascal MÖSLI, Zürich: TVZ, 2003, pp. 45f.

6 Karel CHROMÝ, *Duševní nemoc*, p. 19.

7 Ibid.

8 Cf. Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích.* Praha: Pastorační středisko sv. Vojtěcha při Arcibiskupství Pražském, 2005, p. 33.

conditionally consider a person mentally ill only if a professional has determined the diagnosis ICD-10.[9] These people are often in ambulatory or institutional care of doctors – psychiatrists.

2. Pastoral care – pastoral worker – the problem of awareness

The concept of pastoral care is not clearly defined in our environment. Defining pastoral care may be approached by describing the realizational tasks of the church, as conceived by contemporary pastoral theology. These tasks are expressed with four Greek words: *kerygma* (proclamation), *diakonia* (service to the needy), *leiturgia* (worship, liturgy) and *koinonia* (creation and care of community). The aims and basic principles of pastoral acting are more precisely defined by Aleš Opatrný. According to him "pastoral care in the broader sense means such interaction with a human being, in which we respect him in his uniqueness, approach him from the position of Christian faithful, accompany him in his difficulties, illness, suffering or dying, and help him to a humanly dignified mastering of his life situation including death, at a level of faith accessible to him with the prospect of its possible development."[10] This definition already includes more specific aims and the basic principles of pastoral acting (e.g. approach from the position of Christian faithful or approach at a level of faith accessible to the one being helped).

Along with defining the extension or content of pastoral care it is necessary to do the same with respect to the concept of pastoral worker. In the past the subject of pastoral care was primarily the priest. Although the present Code of Canonical Law (CIC) published in 1983 (can. 375 §1 and can. 515 §1) still defines the shepherd in the specific sense of the word as the bishop, or priest, it also formulates the participation of lay persons[11] in pastoral tasks. The expectation that the laity actively participate in pastoral work is even more clearly formulated in John Paul II.'s exhortation *Christifideles laici*,[12] which underscores that all the baptized are to take part in the realizational tasks of the church.

In pastoral care of the mentally ill the social status of the pastoral worker is not insignificant. It to a great extent determines the possibilities and quality of pastoral work with mentally ill persons.[13] It is a great advantage, and to a certain extent a necessity, for the pastoral worker in the field of pastoral care of the mentally ill to have at least lower specialist education in the field of psychology and psychiatry (courses, psychotherapeutic training and others).[14] This enables him to judge the psychological problems of the person in question at least to the extent that he can recognize the necessity of directing him to the relevant experts who can offer him qualified help.[15]

9 © ÚZIS ČR 2010–2014, ICD-10 Tabular part (actualized second version from 1 January 2013), pp. 189–258, (on-line), at http://www.uzis.cz/zpravy/aktualizace-mkn-10-platnosti-od-1-ledna-2013, retrieved 21 March 2014. For more on classifying mental disorders see Petr SMOLÍK, Klasifikace duševních poruch, in *Psychiatrie,* ed. Cyril HÖSCHL – Jan LIBIGER – Jaromír ŠVESTKA, Praha: TIGIS, 2002, pp. 329–339.

10 Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, p. 9.

11 The concept of lay person is itself equivocal. Here it is used to designate two facts at the same time: 1) From the point of view of church law (CIC 1983, can. 207 § 1) lay persons are all Christians who have not received the sacrament of holy orders. 2) The second reality described by the term 'lay' is lack of formal expertise in the field of clinical psychology or psychiatry.

12 Cf. JAN PAVEL II., *Christifideles laici*, 2nd ed., Praha: ZVON, 1996, par. 23, pp. 40–43.

13 A priest can e.g. administer sacraments.

14 In persons who have graduated from theological faculties and have mostly taken a final exam in psychology such basic knowledge can be expected.

15 Pastoral care of the ill does not concern only pastoral workers, but also medical institutions. These ought to cooperate in this respect with churches and religious societies, since it is a matter of satisfying the spiritual needs of the human being. Every human being has spiritual needs, which need not be religiously topicalized. Care of them belongs to overall care of the ill person and medical institutions should therefore take interest in satisfying them. For more see Aleš OPATRNÝ, Ti, kdo nemocné doprovázejí, in *Praktická teologie pro sociální pracovníky*, ed. Michael MARTINEK a kol., Praha: JABOK, 2008, p. 145.

The problem a pastoral worker faces in pastoral care of mentally ill persons which impedes effective pastoral care is ultimately always a lack of information about the mentally ill person. This information can be divided in two categories: information about the patient's state of health and information about the history of his spiritual life. This deficiency is especially manifest in the environment of mental hospitals, where pastoral care can also take place.

The statutory regulation protecting the patient's privacy does not allow medium and lower medical personnel to provide information on the health state of a patient. Such information, which is part of the medical secret, can in practice only be provided by a doctor, under the strict conditions stipulated by Law 372/2011 Sb., concerning medical services and the conditions of providing them. The main one is explicit consent (in written form) of the patient with providing information concerning his state of health to specific persons who are not his relatives.[16] Without this consent the doctor may provide no information to the pastoral worker. The law does not mention the pastoral worker among those who have the right to information concerning the patient, or the right to inspect medical documentation.[17] The pastoral worker thus mostly has to rely on information from the patient himself. However, due to the mental illness this often misrepresents the situation.

Information concerning the previous spiritual life of the mentally ill person is also important. Lack of this information is especially manifest in patients suffering from a disorder accompanied by delusions (e.g. schizophrenia), or in persons suffering from dementia, since perception of reality (including the past) in these patients can be very different from normal assessment of the past as we are accustomed to it in healthy persons. If the pastoral worker has reliable information concerning the prior full spiritual life of the mentally ill person before his illness broke out (i.e., he is a practicing faithful), he can be more tolerant to the patient's confused attitudes and experiences at present. These need not even hinder administering sacraments. However, the situation is different if the ill person had never known the real meaning of the values sacraments confer. In such case it is recommended to minister to the ill person with a pastoral conversation and possibly help him on his way to God.

3. Some ethical questions related to evaluating mentally ill persons and principles of approaching them

Pastoral work with mentally ill persons comprises the requirement that the pastoral worker can morally evaluate the acting and behavior of a mentally ill person. In the given situation, however, it befits the pastoral worker to morally evaluate only non-pathological phenomena, such as the client's dejection, bad mood or sorrow, and at the same time he can direct him to remove or at least correct them as part of spiritual accompaniment. But in case of an affective disorder, which may be accompanied by the same symptoms as the non-pathological cases, it

16 The statement is based on Law no. 372/2011 Sb., concerning medical care, § 33 par. 1: "*When the p*atient is admitted in care, she can stipulate persons who may be informed of the state of her health, and at the same time can stipulate, whether these persons can inspect the medical documentation concerning her or other records related to her state of health, to make extracts or copies of these documents and whether they can in cases according to § 34 par. 7 give or deny consent to administering medical care. The patient can stipulate persons or forbid providing information concerning the state of her health to any person at any time after admission to care, she can also withdraw the stipulation of person or ban of providing information concerning the state of her health at any time. A record of such statements by the patient is part of the medical documentation concerning her; the record is signed by the patient and a medical worker. The record includes the patient's statement concerning the way in which information concerning the state of her health may be communicated."

17 Law no. 372/2011, concerning medical care, § 65 stipulates persons allowed to inspect medical documentation, or make excerpts or copies of it. The clergy or pastoral workers do not appear here. The persons allowed to inspect documentation according to this paragraph are bound to silence. In the opposite case they are guilty of an administrative offence according to § 117 of the same law. This offence is financially sanctioned (violating the obligation silence up to 1,000,000 CZK; unauthorized providing of documentation up to 500,000 CZK).

is not altogether proper for a pastoral worker to morally evaluate the client, i.e., his behavior, since an affective disorder is a serious mental illness and determining moral responsibility is very problematic in such cases.[18] This basic distinction, as well as many others specifying it, must not be overlooked when fulfilling the requirement above.

Although, as stated above, a mental illness mostly appears without the volitional involvement of the affected person, this does not mean that in individual cases the person in question may not be to a certain extent responsible for the origin and progress of his illness. This claim can be supported by the so-called models of mental disorders, as formulated by contemporary psychiatry. These are "simplified abstractions of individual theories or hypotheses that have been applied in contemporary and past psychiatry."[19] K. Chromý describes eight such models.[20] In each of them the patient's responsibility for his mental state is perceived differently. From our point of view, two of these models are especially worth mentioning – the medical one and the moral one. These models offer different moral evaluation of the acts of a mentally ill person.

In the medical model, which ranks among the most influential and widespread in contemporary psychiatry and serves as the foundation of the view of mental illness presented by this paper, the patient's responsibility for his illness is more or less excluded. On the other hand, the moral (behavioral) model[21] directly assumes a certain measure of responsibility, especially in the course of the illness. However, even within the so-called medical model, for which the etiology of the mental illness is to some extent significant (though it need not be always known), personal responsibility of the mentally ill person for his illness, especially for its outbreak, is admitted in individual cases. This is so especially in cases when the mentally ill person may have contrived a trigger mechanism, e.g. by unhealthy lifestyle or experimenting with drugs. One can be "guilty" of inadequate exposure to stress situations, of willingly engaging with an unsuitable psychosocial environment, or in isolated cases of acting against one's conscience, which may give rise to unmanageable anxiety and others.

In all these cases, when evaluating the patient's moral responsibility for his illness it is ultimately necessary to reflect the extent of his freedom. This decides and codetermines the extent of his responsibility for his overall state. One author dealing with freedom of the will or choice is Helmut Weber.[22] He underscores that not all in a person's life is determined in advance, and therefore freedom of the will and choice must principally exist. On the other hand, he adds that individual givens and specifications of human life can be far-reaching and the space of freedom is often very small. The multiplicity of life can severely limit freedom of acting, or even eliminate it.[23] In individual cases this freedom can be lacking altogether and even throughout the whole life. An example he gives is precisely a grave mental illness.[24] This claim gives grounds to believe that mental illnesses often present a great limitation of freedom of the will and choice, and thereby of the extent of responsibility for one's acting and state of health in mentally ill patients.

18 Cf. Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, p. 82.

19 Karel CHROMÝ, *Duševní nemoc*, p. 27.

20 These models are called: the moral model, the medical or biomedical model, the psychoanalytic model, the defect or handicap model, the family interaction model, the social model, the psychedelic model, the conspiratory model. Cf. Karel CHROMÝ, *Duševní nemoc*, pp. 27–37.

21 At present the moral model takes a behavioral form. "The present (behavioral) version of the model understands (…) a disorder as learned dysfunctional behavior. The mechanism of its origin – unlike its continuation – is insignificant and interpreting it is useless. Remedy consists in eliminating undesirable behavior by means of positive and negative sanctions. (…) Society has the right to protect itself against norm breakers, but it must also offer possibilities to change behavior in the sense of valid norms." Karel CHROMÝ, *Duševní nemoc*, p. 28.

22 Cf. Helmut WEBER, *Všeobecná morální teologie*, Praha: Zvon a Vyšehrad, 1998, pp. 229–231.

23 Cf. ibid., p. 229.

24 Cf. ibid., p. 230.

When morally evaluating a person's responsibility for the outbreak of his illness it is also necessary to account for the fact that one can hardly estimate the possible consequences of his risk behavior. If through no fault of his own the patient had a lack of information concerning the possible consequences of his risk behavior, he can be (at least partially) dispensed from moral responsibility for his mental illness, which he had brought about by such behavior. From this point of view raising awareness concerning mental illnesses and their trigger mechanisms appears to be an urgent educational requirement.

When determining the extent of a mentally ill person's moral responsibility other factors should be taken into account (e.g. the psychosocial environment in the family, at school, at work), that affect the patient's behavior and acting before as well as after the mental illness breaks out. With respect to what has been said above the patient can be blamed for his mental illness only to a limited extent, if we have the right to morally judge people suffering from their illness at all.

High-quality and ethically justifiable pastoral care of mentally ill persons is conditioned not only by a certain reserve in ethically evaluating their acting, but also by observing certain principles of approaching them. These principles can be divided into general ones, which ought to apply to approaching all mentally ill persons, and specific ones, which can be applied only when dealing with individual types of mental disorders.[25]

One of the most general principles of approaching a mentally ill person is to *accept the ill person unconditionally, without prejudices, resentment and condemnation.*[26] This need not be easy in particular cases. If, however, the pastoral worker is incapable of that, he had better refrain from pastorally engaging in this field.

In the sphere of life of faith the principle of proportionality and acceptability applies. This holds especially for the practice of administering sacraments and other religious actions, as well as in conferring spiritual advice. Here it is necessary to recall the main principle of medical ethics, which is *Primum non nocere* (i.e., first, do no harm). Disproportionality in the religious sphere can harm a mentally ill person. The criterion of proportionality in these cases is the kind of mental illness and the ill person's current state of health.[27] To this one must add the pastoral worker's competency to distinguish what a mentally ill person in a given state of health "can and cannot do, what in the sphere of life of faith and pious practice can be of benefit to him and what causes him harm."[28] In this "consists the fundamental core of good pastoral care of the ill (as well as the healthy)."[29]

Conclusion

The ambition of this paper has not been to present the problems associated with pastoral work with mentally ill people in an exhaustive manner. We have only focused at two levels of the problem. These are the widespread prejudices against the mentally ill and the problem of frequently insufficient awareness of the pastoral worker of a mentally ill person's real state. Both

25 We can also imagine the principles on a continual scale from the most general ones to the most specific ones, which respect the human being in her individuality.

26 Cf. Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, p. 34.

27 Cf. Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, pp. 82-87.

28 Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, p. 34.

29 Aleš OPATRNÝ, *Pastorační péče v méně obvyklých situacích*, p. 34.

cases manifest a certain "incapacity" on the part of the pastoral worker to change these facts. Nonetheless, this may not prevent him from striving to provide high quality pastoral care to mentally ill people even in such conditions. The basic precondition for that seems to be not only appropriate expert erudition, especially in the sphere of psychology or psychiatry, but also ethical erudition, i.e., ability to reflect the ethical questions associated with this practice.

However, we have tried to point out that when working with mentally ill persons the pastoral worker is confronted with a number of ethical questions, to which he ought to be able to sensitively and at the same time truthfully react. The basic requirement for such work is respect for the mentally ill person. This should result in an approach appropriate to the ill person's situation and possibilities. In other words, the pastoral worker should be sensitive to the needs of the mentally ill person. He should be able to discern and correctly evaluate his behavior, i.e., sufficiently account for the measure of his personal freedom and responsibility. In this, we believe, the central dimension of high quality, ethically justifiable pastoral work with mentally ill persons is concealed.

Some Problems and Ethical Questions Concerning Pastoral Care of Mentally Ill Persons

Abstract The paper reflects the quality of pastoral work with mentally ill people. It focuses on selected issues of this practice and ethical questions related to them. These are first of all widespread prejudices against mentally ill people and the fact that pastoral workers have insufficient information about their state of health or their spiritual life before their illness broke out. The paper notes and underlines general principles that should guide pastoral work with such people and evaluation of their behavior in terms of ethics. Pastoral care of mentally ill people is to be professionally erudite and ethically justifiable.

Key words pastoral care, ethics, mental illness, mentally ill person, prejudice, awareness