Ethical, anti-racist pastoral care with women with mental illness

A research note on *Just Care*

Leah R. Thomas

During the years of 2009–2017, I was a chaplain at an in-patient psychiatric facility.[1] Repeatedly, I found myself in fraught conversations with other chaplains about how "best" to care for the patients with whom we were ministering—particularly when these patients lived at the intersection of multiple marginalizing forces: they were women, frequently of color, from limited economic means, and struggling with severe mental illness. The presence of violence was also often a part of their narrative. What did it look like to offer care that honored their unique social location and also was attentive to the surrounding culture—both of the larger society and of the in-patient facility itself? Where could we go to find answers to these questions? Conversations like these led me to the research that is at the heart of my book *Just Care: Ethical Anti-Racist Pastoral Care with Women with Mental Illness*.

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Just Care arose out of a recognition that the discipline of pastoral care within the Protestant Christian tradition has largely ignored ministry with those with severe mental illness. When it has addressed this area, it has tended to lack attention to the larger social and cultural dynamics that surround, frame, and interpenetrate these encounters. Attending to these larger dynamics is increasingly important, particularly when the care seek-

1 This article is a summary of my book *Just Care: Ethical Anti-Racist Pastoral Care with Women with Mental Illness* (Lexington/Fortress 2020). These concepts are explored in a more in-depth manner in the chapters of *Just Care*.

er is a woman of color. *Just Care* proposes a psychosocial spiritual model of caregiving that remains aware of and attuned to these larger factors.

Interviews

As I began to research this topic, my "fraught conversations" evolved into eighteen interviews with psychiatric caregivers in a northeastern state in the United States. These caregivers expressed a number of sentiments. First, they spoke of the predominance of the Western medical model in their ministry. They were united in their assertion that they endeavored to hold the full humanity of women in a system and on a team that they perceived to be reductionistic. Another factor that was not overtly articulated, but was something I observed, was the notable absence of reflection on racial and cultural dynamics within the pastoral encounter. During the interviews, it was apparent that many white chaplains could not even speak about the concept of race, much less reflect on the ways it might be influencing and impacting their care.

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Of the fourteen white people who were interviewed about times when racial or cultural dynamics emerged in their interactions, half of them (seven) answered the question about racial dynamics by either denying that race was a factor in the pastoral encounter or shifting the topic to other issues, including socioeconomic, gender, sexual orientation, or religious diversity. Of the remaining seven, five did offer a brief reflection on racial dynamics, but often they did not spend more than one sentence on their own racial identity. Only two offered in-depth reflections on the racial dynamics in their encounters.

By contrast, the voices of chaplains of color easily offered insights on the role of race and racism in the pastoral encounter. They spoke of the myriad ways that racism affected and interacted with mental health and diagnosis, including attention to the role of racism-induced stress in the

etiology of mental illness, links between racism and institutionalization, and the overrepresentation of those in poverty in custodial institutions.[2]

Research

Other research in the area of psychiatric chaplaincy supports the themes that emerged from these interviews. The dominance of the Western treatment model is widely attested to, and pastoral theologians have had a variety of responses to this reality. Among these responses are those who have attempted to learn more about the intricacies of diagnosis, with the aim of engaging in a dialogue between ministry and psychiatry. Books like *Ministry with Persons with Mental Illness and their Families* and *The Minister's Guide to Psychological Disorders and Their Treatments* are emblematic of this trend.[3] In their quest to learn more about psychological disorders, however, these scholars have largely remained within the Western medical model.[4]

Scholars within the fields of both psychiatry and pastoral care also note that connections between a diagnosis of mental illness and concepts of race, gender, culture, and socioeconomic class have not been adequately addressed. As I note in *Just Care*, women are more frequently diagnosed with mental illness than men,[5] and women who are disadvantaged by poverty or who are of color are more likely than white women of higher socioeconomic strata to experience mental disorder and less likely to seek

2 See Kenneth P. Lindsey and Gordon L. Paul, "Involuntary Commitments to Public Mental Institutions: Issues Involving the Overrepresentation of Blacks and Assessment of Relative Functioning," *Psychological Bulletin* 106, no. 2 (1989): 171–83, quoted in John Townsend, "Racial, Ethnic, and Mental Illness," in *Mental Health, Racism and Sexism*, edited by Charles V. Willie et al. (Pittsburgh: University of Pittsburgh Press, 1995), 133.

3 Robert H Albers, William H. Meller, and Steven D. Thurber, eds., *Ministry with Persons with Mental Illness and their Families* (Minneapolis: Fortress, 2012); W. Brad Johnson and William L. Johnson, *The Minister's Guide to Psychological Disorders and Their Treatments*, 2nd ed. (New York: Routledge, 2014).

4 Another group of pastoral caregivers has effectively sidelined the concept of diagnosis, harboring a sense of inadequacy about their ability to minister with people who have mental illness. Yet in doing so, these caregivers and scholars also do not trouble the basic assumptions and values that undergird the Western medical model.

5 See *Just Care*, 2. This phenomenon has been explored in Daniel Freeman and Jason Freeman, *The Stressed Sex: Uncovering the Truth about Men, Women, and Mental Health* (New York: Oxford University Press, 2013), in which the researchers analyzed twelve large-scale surveys from the United Kingdom, United States, Europe, Australia, New Zealand, South Africa, and Chile. With results that were fairly consistent across race and culture, their findings show that women appear to experience psychological disorder 20–40 percent more frequently than men.

treatment.[6] Women with mental illness—particularly those in psychiatric institutions—exist at the intersection of multiple dehumanizing systems. Christie Cozad Neuger draws connections between the onset of mental illness and social forces, particularly those stressors that tend to be more common among women, such as intimate violence and generational poverty.[7] When women of color enter a psychiatric facility, they are also more likely to end up misdiagnosed than their white counterparts, increasing the likelihood that they will receive pharmacological intervention rather than other forms of therapeutic intervention.[8] When they are discharged, they are more likely to endure poor living conditions or have issues with their physical health.[9] Yet, realities such as this are rarely recognized within systems of diagnosis within the psychiatric hospital and within pastoral caregiving. The majority of pastoral caregivers within psychiatric facilities are also white, practicing ministry in the midst of populations that reflect a significant amount of racial and ethnic diversity.

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6 See Nancy Grote et al., "Engaging Women who are Depressed and Economically Disadvantaged in Mental Health Treatment," *Social Work* 52, no. 4 (2007): 295–308; Ronald C. Kessler et al., "A New Perspective on the Relationships among Race, Social Class, and Psychological Distress," *Journal of Health and Social Behavior* 27 (1986): 107–115; Stevan E. Hobfoll et al., "Depression Prevalence and Incidence among Inner-city Pregnant and Postpartum Women," *Journal of Consulting and Clinical Psychology* 63 (1995): 445–53.

7 See Christie Cozad Neuger, *Counseling Women: A Narrative, Pastoral Approach* (Minneapolis: Augsburg Fortress, 2001).

8 As I note in chapter one of *Just Care*, both Blacks and Hispanics are more likely to be diagnosed with schizophrenia than whites. See Aana Vigen, *Women, Ethics and Inequality in U.S. Healthcare: "To Count Among the Living"* (New York: Palgrave, 2006), 3. As Vigen notes elsewhere, "Both US and British psychiatrists are more likely to prescribe antipsychotic medications, hospitalize involuntarily, and place nonwhite patients in seclusion once hospitalized than their white counterparts, independent of appropriateness of clinical factors," quoting Michelle Van Ryn, "Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care," *Medical Care* 40, no. 1 (2002): I-140–I-151, I-142.

9 See Enric J. Novella, "Mental Health Care and the Politics of Inclusion: A Social Systems Account of Psychiatric Deinstitutionalization," *Theoretical Medicine and Bioethics* 31, no. 6 (2010): 411–27.

The centrality of justice in pastoral care

Given these realities, *Just Care* asserts that a commitment to justice is *foundational* for ethical pastoral care with women in psychiatric institutions. How do we practice care that embodies the centrality of justice amid systems that are frequently unjust? Here I find it important to turn to insights from feminist, womanist, and liberationist scholars of pastoral care and Christian social ethics. These two interdisciplinary conversation partners provide a lens by which to recognize both the individual and systemic components of the relationship between the pastoral caregiver and the woman, components that must be addressed if we are to offer care that has justice at its center.

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Feminist, womanist, liberationist, and intercultural pastoral theologians recognize that the discipline of pastoral care itself has historically been dominated by an androcentric, individualistic approach that has been defined by whiteness, patriarchy, privilege, and US and Western European cultural values. They reveal how these models have been inattentive to broader social systems and to the needs of women and other marginalized groups, and they have responded by advancing communal, contextual paradigms that are attentive to race, gender, and class.[10] Likewise, the emphases of Christian social ethics—the "structures, institutions, processes, systems, and the ways in which individuals and groups both

10 See Stephen Pattison, *Liberation Theology and Pastoral Care* (Cambridge: Cambridge University Press, 1994); Jeanne Stevenson Moessner, *In Her Own Time: Women and Developmental Issues in Pastoral Care* (Minneapolis: Augsburg Fortress, 2000); Christie Cozad Neuger, *Counseling Women*; Sheryl Kujawa-Holbrook, ed., *Injustice and the Care of Sounds: Taking Oppression Seriously in Pastoral Care* (Minneapolis: Augsburg Fortress, 2009); Joretta Marshall and Duane Bidwell, eds., *The Formation of Pastoral Counselors: Challenges and Opportunities* (New York: Haworth, 2006); Emmauel Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (New York: Kingsley, 2003); Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*, rev. ed. (Louisville: John Knox, 2014); Caroll Watkins Ali, *Survival and Liberation: Pastoral Theology in African American Context* (St. Louis: Chalice, 1999); Phillis Isabella Sheppard, "Fleshing the Theory: A Critical Analysis of Select Theories of the Body in Light of African American Women's Experience," PhD diss., Chicago Theological Seminary, 1997; and Phillis Isabella Sheppard, *Self, Culture and Others in Womanist Practical Theology* (New York: Palgrave MacMillan, 2011).

respond and shape them"[11]–are crucial to an analysis of pastoral care with women with mental illness. Christian social ethics provides a necessary corrective lens to the historic bias of pastoral care, which has tended to focus on the individual. Christian social ethics also points toward the transformation of the larger systemic reality. In the words of Emilie Townes, a womanist ethic "is never content to merely react to the situation: it seeks to change the situation."[12]

Yet, within both of these fields, there is often little attention to those with severe mental illness.[13] What would it mean to expand the focus of pastoral caregiving with women to include the presence of severe mental illness and its relationship to the Western medical model, including the structures, institutions, and systems that surround it? *Just Care* attempts to expand this discourse by placing the voices of psychiatric caregivers at the center of its moral discourse. It puts these voices into dialogue with feminist, womanist, and intercultural scholars of pastoral care and feminist and womanist scholars of Christian social ethics to form a trialogue. This model holds in tension the particularity of each encounter with the systemic factors that surround and permeate this encounter in order to provide ethical anti-racist pastoral care.

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Pastoral care and race

Attention to the work of both Christian social ethicists and psychologists provides context for and analysis of the responses of the white people

11 Emilie Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care* (New York: Continuum, 1998), 2.

12 Emilie M. Townes, "Living in the New Jerusalem: The Rhetoric and Movement of Liberation in the House of Evil," in *A Troubling in My Soul: Womanist Perspectives on Evil and Suffering*, ed. Emilie M. Townes (New York: Orbis, 2001), 84.

13 While feminist, womanist, and intercultural scholars of pastoral care have focused much on contextual analyses of women and trauma, the presence of severe mental illness (beyond trauma) is frequently not a focus. Christian social ethics is frequently attentive to a systemic analysis of health and healthcare, including the ways in which this system disadvantages women; yet very little in the discourse around health in social ethics addresses severe mental illness.

who had difficulty speaking about race. Jen Harvey's examination of the historical rise of the term *white*,[14] alongside explorations of white dominance and white privilege by Traci West,[15] note that the term *white* came into existence to justify the systemic violence and oppression of those with darker skin through the institution of slavery. Christians continued to support and justify systemic racial violence through both their interpretations of the Bible and liturgical practices. The term *white* is therefore not a neutral term; it is the product of racially motivated violence and oppression, from which white people continue to benefit (both materially and socially). Because white people have not engaged in a communal disruption and refusal of white privilege, to be white is "to exist in a state of profound moral crisis."[16]

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Alongside insights from Christian social ethicists like Harvey and West, Derald Wing Sue, a psychologist, draws on the research of Eduardo Bonilla-Silva to offer possible explanations for the reactions of whites when confronted with questions regarding race and racial identity.[17] When white people recognize that they are part of a system that advantages themselves (while disadvantaging people of color), they are confronted with emotions such as fear, guilt, and defensiveness. As such, whites tend to turn toward avoidance, ignorance, distortion, and rationalization rather than engage in the difficult work of confronting their own racial identity. Intersectional analyses, particularly those focused on the impact of race and racialized dynamics, have yet to be applied to the particular situation of women caught in the

14 Jennifer Harvey, *Dear White Christians: For Those Still Longing for Racial Reconciliation* (Grand Rapids: Eerdmans, 2014), 56.

15 Traci C. West, *Wounds of the Spirit* (New York: New York University, 1999).

16 Harvey, *Dear White Christians*, 56.

17 Eduardo Bonilla-Silva, in "Linguistics of Color Blind Racism: How to Talk Nasty about Blacks without Sounding 'Racist,'" *Critical Sociology* 28 (2002): 41–64, proposes what he terms "color-blind racism." Color-blind racial attitudes allow whites to deny their advantage and maintain the veneer of racial equality and meritocracy. Among characteristics of color-blind racism are "rhetorical incoherence," which is characterized by "grammatical mistakes, lengthy pauses, and repetition in speech when discussing sensitive racial issues" (58).

culture of the psychiatric hospital. *Just Care* invites the analyses of Harvey, West, Bonilla-Silva, and Sue into conversations around the responses of white chaplains in my interviews, offering potential explanations of their noticeable difficulty in conversing around race. These insights provide a starting point for addressing some of the inter- and intra-personal dynamics that are central to anti-racist, justice-centered pastoral care.

The practice of *Just Care*

Just Care prioritizes the place of power, race, gender, and class as "necessary theoretical tools" in an analysis of the presence (and absence) of justice.[18] The core components of the practice of *Just Care* spring from this wider commitment as follows:[19]

1. *Care that begins with the woman. Just Care* first and foremost recognizes the beauty, sanctity, and dignity of each woman who resides in a psychiatric hospital. Caregiving must begin with the sacredness of their stories, alongside respect for the immense stressors under which they live. It also recognizes the intersection between these stressors and a larger culture that can reduce and infantilize them due to their gender, race, mental illness, or socioeconomic status.
2. *Awareness of the chaplain's own social position, cultural context, and embedded and lived theologies. Just Care* privileges the intentional exploration of the caregiver's own social positionality, cultural context, and embedded and lived theologies, notably those factors that cause her to see the other through the lens of her own experience. It advocates for both membership in accountability groups and education about how race, culture, and gender impact communication styles to aid caregivers in this journey.
3. *Care that is both communal and individual.* Communal care recognizes that a society marked by intersections of patriarchy, racism, and classism renders certain groups of women stigmatized and disenfranchised in intensely complicated ways. The system of psychiatric diagnosis has evolved within this society

18 Townes, *Breaking the Fine Rain of Death*, 1.

19 For the purpose of this article, these are brief summaries of these concepts. For a more in-depth exploration of each of these factors, see *Just Care*, chapter 4.

and can be a reflection of these dynamics. Diagnosis can also function as a tool for dismissal of communal responsibility for the care of women with mental illness.[20] *Just Care*, in its commitment to communal care, asserts the moral responsibility of communities to challenge those structures that create stressors in women's lives that may culminate in mental illness and institutionalization of women. At the same time, it also privileges the ways that the one-on-one encounter between the caregiver and care seeker has the potential to be transformative in the lives of both parties.

4. *Care that is attentive to the intersection of culture, gender, race, and class. Just Care* notes that factors such as racism, sexism, heterosexism, and classism intersect in a particular way in the lives of women who are institutionalized in a psychiatric hospital, which itself has a regulated culture that might be influencing (or rendering invisible) the above factors. For example, African American women may exhibit different signs and symptoms of depression (or of the presence of intimate violence in their lives) than standards that put white people at the center would indicate.[21] A racial and cultural analysis must be present in every part of the interaction between the caregiver and care seeker. This commitment requires that the caregiver explore not only the emotional and spiritual health of women but also tangible, recurrent concerns (such as employment and housing discrimination). As noted by West, if the healing process for women of color does not incorporate material realities, it "will be perpetually unsatisfactory and insufficient."[22]

5. *Care that recognizes the power of encounter.* Neuger notes that, in the context of a caregiving encounter, belief in what a woman is saying is fundamental to helping her gain "voice

20 West asserts that when anguish becomes collapsed with psychotic behavior, it becomes "a scientifically validated method of community dismissal" (*Wounds of the Spirit*, 124).

21 Townes draws on Pouissant to note that, while Black women experience depression, the symptoms are frequently manifested differently. Black women, for example, may experience increased activity as opposed to lethargy, lack of interest in activities, and trouble eating or sleeping (*Breaking the Fine Rain of Death*, 155).

22 West, *Wounds of the Spirit*, 177.

and agency."[23] This is even truer in a psychiatric setting. The caregiving relationship must be rooted in empathy, alongside a commitment to enter the world of the woman experiencing hallucinations or delusions in order to "seek to find the essential human being lost in the seemingly uncanny."[24] *Just Care* holds up the power of encounter as generative of something larger than each of the participants, aiding both participants in an exploration of a life-giving relationship with themselves, the other, and God.

6. *Care that has an expansive view of health and healing.* A commitment to the interconnected and expansive nature of health, as well as resistance to anything that seeks to reduce the woman's health to a one-dimensional concept, is an important component of *Just Care*. *Just Care* seeks the health and well-being of the entire woman—mental, emotional, spiritual, and physical. It also builds on Townes to propose that "health is not simply the absence of disease—it comprises a wide range of activities that foster healing and wholeness."[25] Health is rooted in relationships and activities that foster dignity and wholeness *in the midst* of mental illness. *Just Care* advocates for a definition of health that incorporates an expansive notion of the self, which includes a woman's racial identity, gender identity, sexual orientation, and culture, alongside her physical, mental, emotional, and spiritual health.

7. *Care that is advocacy oriented.* Chaplains overwhelmingly spoke of the importance of being an advocate for the patient, both within the hospital and concerning issues of discharge. *Just Care* recognizes that voices of resistance are frequently subsumed in larger bureaucracies that can flatten and de-politicize these dissenting voices. At the same time, *Just Care* follows the lead of Stephen Pattison and his recommendation that advocacy within the hospital involves embracing what many chaplains are already doing—that is, raising their voice in protest of the system that engages in a reductionistic view

23 Cozad Neuger, *Counseling Women*, 89.

24 Michael Garrett, "Introduction: Psychotherapy for Psychosis," *American Journal of Psychotherapy* 70, no 1 (2016): 3.

25 Townes, *Breaking the Fine Rain of Death*, 2.

of women, as well as advocating that the patient be taken seriously when decisions about her are being made.[26] A commitment to advocacy as a component of *Just Care* prompts chaplains also to engage in social and political activities that direct society's attention and resources toward women who are mentally ill, including (but not limited to) the education and mobilization of church communities.

8. *Care that puts spirituality at the center. Just Care* holds that it is in and through religion and spirituality that healing and integration can occur (though this does not preclude other sources of healing). It recognizes that spirituality is a source of strength for many women who experience mental illness, particularly for women of color. For other women, the presence of mental illness can cause them to feel that they have been abandoned by God. In either case, spirituality provides an entry point from which to commence an analysis of meaning, a way in which the care seeker can begin to make sense of her journey, quest, purpose, and relationships in her life. Ultimately, the caregiver seeks to journey with the woman to uncover those aspects of her spirituality that draw her closer to her "source of meaning, value, hope and transcendence" while also being able to name those aspects that draw her away from emotional, spiritual, and psychological health.[27] *Just Care* also recognizes that assessments of the "health" of religious beliefs must be contextual and informed by analyses that are attentive to racial, cultural, gendered, and socioeconomic factors. In any of these circumstances, however, religious beliefs that do not emphasize women's inherent dignity and self-worth would need to be interrogated.

The components of *Just Care* create a tangible, ethical practice of care that has the potential not only to impact caregiving with women with mental illness but also to invite reflection on the current education and training of chaplains and the racial and gendered composition of chaplaincy staffs. Ultimately, *Just Care* invites caregivers to embrace a model of caregiving that seeks to hold the full humanity of the woman by offering

26 Pattison, *Pastoral Care,* 179–182.

27 John Swinton, *Spirituality and Mental Health Care: Rediscovering a Forgotten Dimension* (Philadelphia: Kingsley, 2001), 172.

contextually sensitive care that also honors the power and sacredness of individual encounter.

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