Quiet Conversations, Lifeline Moments

Catholic chaplaincy in mental health care.

By: Richard Hadley BCC

The door to a behavioral health unit closes with a soft click that feels louder than it is. Behind it are bright hallways, locked cabinets, group rooms with circles of chairs, and people carrying stories too heavy to hold alone.

In that space, a Catholic chaplain's work isn't a sermon. It's a presence.

"I describe my ministry as an honorable calling to meaningfully, compassionately journey alongside individuals of all cultures and backgrounds as they invite me to, or accept my offering of, spiritual and emotional support," said Dolphus Vest, Mental Behavioral Health Chaplain at a Level 1 trauma hospital in Virginia.

He's not there to fix anyone. He's there to show up, especially when life feels fractured by depression, addiction, anxiety, psychosis, grief, trauma, or the slow erosion of hope.

And while mental health treatment often centers on medication, therapy, and safety plans, chaplains in behavioral health insist on something that can be harder to measure: meaning.

"Whole-person care" and the part that's hardest to define

In hospitals, "whole-person care" has become a familiar phrase. It's printed on mission statements and woven into quality initiatives. But on a mental health floor, whole-person care becomes intensely practical: a patient's beliefs can be an anchor or a comfort, or they can be a source of shame.

Vest has seen both. "Thankfully," he said, "I have been blessed that the interdisciplinary team I work with appears to understand the importance of spiritual care as part of the patient's treatment and a way to tap into healthy coping skills."

That teamwork matters. In behavioral health, a patient might be learning grounding skills in group therapy, building routines with occupational therapy, meeting with a psychiatrist about medication side effects, and wrestling in private with spiritual questions that don't neatly fit any worksheet.

Whole-person care can get complicated fast, especially when religion and symptoms blur together. What does forgiveness look like after relapse? How do you pray when your mind won't rest? Where is God when you can't get out of bed? The chaplain's job is to sit inside those questions without rushing them to resolution.

"From both a staff and patient point of view," said Vest, "I have found that the line between healthy spiritual connection and 'hyper-religious' is not always understood.

Never talk to a patient's hallucination but allow space for them to describe what they are seeing or experiencing.

"The phrase hyper-religious can mean a lot of things," he added, "depending on who's using it." Chaplains may encounter it from a staff member uneasy with faith language, a clinician trying to describe a symptom, or a patient clinging to religious ideas as a last thread of control. "If there is not a study to define possible markers for both, then there should be."

Spiritual care is not separate from mental wellness

On a unit where people may experience hallucinations, delusions, mania, or severe anxiety, spiritual language can sometimes become part of the storm. A chaplain must be careful not to amplify it — and equally careful not to dismiss what might be deeply sincere. That's the tightrope: honoring belief while guarding safety.

"A patient connecting to their faith is an important part of achieving mental and emotional health goals," Vest explained, "even in the uncertainty of a specific diagnosis."

Vest said a misconception he sometimes encounters is the idea that spiritual support and emotional support are entirely different from mental wellness. In behavioral health, chaplains build meaning and resilience in the midst of mental and emotional distress. "I call it a beautiful blend."

Vest recalled a patient he visited twice. The patient, declining mentally, did not remember him on the second visit and required focus to

Chaplaincy in behavioral health requires discernment: What supports this person's stability right now? What helps them feel grounded?

manage words, so much so that one sentence might take up to two minutes. In that 30-minute visit, they only exchanged a few sentences, but the patient communicated to him, "Scripture … for encouragement."

Vest said the patient expressed happiness from the visit. The next day the patient again did not remember him, but requested prayer. "The patient's spiritual and emotional needs were met," he said.

More than idealism, it's practicality

On a unit, lucidity can shift hour to hour. A patient might be disorganized in the morning, clearer by afternoon, and overwhelmed again by evening. Someone might not remember a chaplain visit, but the tone of that visit can still affect their nervous system, their sense of safety, and their trust in care.

And even when a person's thoughts are fragmented, their need for dignity remains intact.

Vest recalled patients using Dialectical Behavior Therapy (DBT), a structured approach that teaches skills like mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Some patients shared their DBT worksheets and lists of coping strategies with him.

"I was able to utilize certain aspects of their therapeutic goals," he said, "to assist them in connecting to their spiritual journey or to enhance the ways they connect to their beliefs."

In other words, the chaplain doesn't replace therapy; he works alongside it.

A patient practicing mindfulness might find that mindful breathing becomes a bridge to contemplative prayer. A patient building distress tolerance might reinterpret a painful moment through the lens of spiritual endurance, hope, or compassion. A patient working on interpersonal boundaries might explore forgiveness, not as instant reconciliation, but as a process that protects their dignity.

It's not about turning clinical tools into religious tools. It's about helping patients locate their strengths, including spiritual ones, in ways that support their treatment goals.

Our clergy need care, too

Kathy Brown DMin is an educator and spiritual director. She is the Director of Spiritual Care at the Saint Luke Institute in Silver Spring, Maryland, which provides compassionate mental health care and assessments for Catholic clergy and religious. In this setting, spiritual direction is an integral part of treatment, and it enjoys the same privacy rights as all other medical information under HIPAA.

"Spiritual," Brown said, "is a different lens on their care. Spiritual integration is something that clergy and religious have been doing for decades. Their faith is such a part of who they are."

It is easy to forget the emotional and mental care needs of those who we see as our support-givers. "Trauma in their past continues to affect their spirit and emotions," she added. For some, it isn't just unresolved personal trauma, but the burdens they have picked up and carried from others through empathy over their many years of ministry — the stories they have heard and continue to live with.

Brown noted that the experiences of trauma continue to live in the body and that it is not just the body, but the soul that keeps score. "Our treatment here doesn't approach them as a collection of parts, but as a whole — and we are at work here to make them whole again."

Mental and behavioral health chaplaincy is unique

"Patients connecting to their faith is an important part of possibly achieving their mental and emotional health and goals," said Vest.

That word, possibly, is doing important work. It signals humility. Not every patient is religious. Not every religious framework is helpful at every moment. Chaplaincy in behavioral health

requires discernment: What supports this person's stability right now? What helps them feel grounded? What reduces harm?

And sometimes, the most supportive spiritual care is simply making space for someone to speak honestly, without being corrected.

The skills that matter most: calmness, authenticity, and boundaries

In a behavioral health setting, authenticity is not a branding statement, it's a stabilizer. Patients often have finely tuned radar for performance. If a chaplain offers platitudes, it can feel like abandonment. If a chaplain becomes visibly uncomfortable, it can heighten shame.

Calm honesty using acknowledging phrases like, "I hear you," "That sounds terrifying," "I'm here with you," "I can't support that request, but I won't leave you alone in this," builds trust.

When hallucinations enter the room

One of the most delicate parts of the chaplain's work is navigating hallucinations and delusions without reinforcing them.

"Never talk to a patient's hallucination," said Vest. But that doesn't mean shutting the person down. Instead, he advised chaplains to focus on what the experience is doing to the patient.

"Provide space for them to tell you about what they see or experience," he added, "as it may lead to their lament and provide a meaningful connection with you to offer effective spiritual and emotional support."

That approach respects both clinical safety and spiritual dignity. It avoids validating the content of hallucinations while validating the person's fear, grief, confusion, or loneliness.

Patient lucidity can sometimes change on an hourly basis. While patients may not remember the exact words you use, your tone will often linger.

Pocket Guide for Presence

Vest keeps a set of reminders handy. They're the kind forged in real encounters, not theoretical training.

Never take things personally. It is about the patient, not you.

Do not be judgmental.

Maintain calm, active, and responsive listening.

Stay authentic. Do not tell patients what they want to hear.

When needed, give guidance, not advice.

All patients deserve to be visited, if they want a visit.

Stay safe. There are times it is not appropriate to proceed.

It's the difference between saying, "Yes, the voice is real," and saying, "That sounds exhausting. What is it like to carry that all day?"

In behavioral health, that distinction can protect a patient's treatment progress — and still honor their humanity.

Fear is contagious: chaplains can't afford it

Patients on mental health units are often sensitive to power, rejection, and threat. A chaplain's fear, even unspoken, can ripple. "Chaplains shouldn't act afraid of patients if they are not threatening you," advised Vest.

He's careful not to minimize risk. Chaplaincy includes vigilance. "Always be cautious, but make informed assessments and follow your instincts. Stay safe and remember there are times it is not appropriate to proceed with a visit, especially when a patient is screaming and yelling, not coherent and is aggressive, or becomes angry when you cannot honor a request outside of ethics or a facility's guidelines."

Safety, in other words, is not a lack of compassion. It's a form of responsible care for the patient, for the staff, and for the chaplain.

The ministry that happens in small moments

If you ask chaplains in behavioral health what they do all day, you might not hear dramatic stories. You might hear about ordinary moments that become extraordinary because someone is finally not alone. A patient who hasn't spoken in group therapy whispers grief in a quiet hallway. A person in recovery wonders if they've broken God's patience. A teenager misses their grandmother's rosary but is afraid to ask for prayer. A patient wants forgiveness but doesn't know how to forgive themselves. Someone with racing thoughts needs a steady voice saying, "Breathe with me."

In those moments, chaplaincy looks less like answers and more like accompaniment, or the willingness to walk beside someone without needing to control the outcome.

Chaplains often refer to their work as an honorable calling. Not because it's glamorous; it isn't. Not because it always feels successful; it won't. But because it asks for a rare combination of tenderness and restraint, faith and humility, courage and clinical awareness.

And in mental health care, where suffering can isolate and stigma can silence, that kind of presence can be its own form of medicine.