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Opinions expressed in the editorial and articles within this publication do not necessarily represent the views of the Editorial team, College of Health Care Chaplains or Amicus.



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EDITORIAL

Simon Harrison

I guess I should begin with a couple of corrections from the last edition. Firstly, Chris Swift has not now retired as president of CHCC, and so lives to enjoy some feedback on his article in this edition! We have also not yet added a further 'acute general' Chaplain onto the editorial team to improve capacity, but will do soon.

In the spirit of apology, and more serious than the above, I am sorry that this edition has not been as early as I hope you are coming to expect. This was not from lack of articles, far from it (and apologies to those whose submissions were not accepted this time), but rather due to a couple of life events depriving the editor of sleep.

Selecting articles for inclusion was more difficult for this edition than for any previous edition I have edited and I am pressed to explain why. It may be due in part to our stated desire to expand the range of articles submitted and included. Great in theory, but how do we then judge between such disparate styles? Is an impassioned but technically flawed piece more space-worthy than an immaculately scripted piece with only specialized appeal? Also challenging can be faith specific pieces or works which are stylistically limited to the author's tradition. We like authors to consider the breadth of our readership, but acknowledge that some will not have the knowledge or confidence to write to such a wide audience. How high should we set the bar on this issue? Is it more or less important than other quality issues, such as referencing, use of recent research, etc.?

I think it fair to say that the editorial team has a healthy range of views about where the bar should be set and what counts as a high-quality article. As always, I must take personal responsibility for what is included, even though I depend heavily on the wider team for advice. For this edition, I decided in the end to include a greater range of mental health articles than you might normally expect, which may be balanced by fewer in the next edition. These things seem to come in waves: you may remember a few editions ago we had a wave of submissions concerning baptismal practice, not all of which could be accommodated. We have also decided to include a couple of articles based on talks given at events only a few chaplains may have attended (*Robin McGlashan, David Hamilton*). Do let us know if you wish us to continue with this or whether you find the different style distracting.

This debate has led me to wonder what submissions we shall get in future. If KSF has its desired impact on those of us employed under Agenda for Change, we should get an increase in competent academic and professional reflection pieces. If Chaplaincy Academic and Accreditation Board (CAAB) have their intended impact on professional standards, articles may reflect a broader body of knowledge within Chaplaincy, spanning sociology, world faiths, human relationships, organizations and so on. If I had to lay money on it, I believe articles will continue to reflect the personal passions of individual chaplains. It always seems to take such passion to change an idea into a crafted piece of research or

writing. So the question is perhaps more subtle: what will stir the passion of chaplains in the coming months and years?

For one thing, I would hope the seismic impact of possible redundancies will stimulate a range of submissions and sharpen up our thinking about what makes Chaplaincy a vital feature of any healthcare services. Some of these may be passionate, some more academic, tightly argued or evidence/research based. The future growth or contraction of Chaplaincy will be affected by shifts in society and the NHS that are well beyond individual control (changes in Standards for Better Health, shifts in patient expectation, personnel in government, etc), but I believe each one of us has the potential to affect the quality and form of future provision. Articles here and in other journals (e.g. The Scottish Association of Chaplains in Healthcare (SACH)) should be prompting new thinking on all the basic issues of practice: e.g. should smaller mental health units just accept that on-call provision is either redundant, or at the least impossible in the light of the working time directive? Can posts justify a necessary link with faith bodies as we focus more and more on Chaplaincy competencies rather than an individual's status within a faith community? Will patients increasingly understand or be bewildered by our membership of the MDT?

Good articles, well read, can make all the difference. Let me share a personal example. Before I took up this post, I read a piece on naval Chaplaincy which included a reflection on rank, intimating (to my recollection) that, beyond a nominal rank, the naval Chaplain is also deemed to have equal rank with the highest ranked officer present. This allows the Chaplain to serve and relate to the whole crew without some of the interference of hierarchy. This seemed to give great freedom within the community and I decided unilaterally to adopt this understanding in my new post within a Mental Health Trust. Remarkably, with only one or two exceptions, this seemed easily accepted by all. Having such a clear self-understanding of my role as Chaplain to the organization made it easier for me to model relationships with both housekeeper and non-executive, nurse and senior manager. Whatever the pros and cons of this model, the fact is that just one article shaped my whole way of working unlike any other. My hope is that the article you are thinking of submitting will become a reality and have as much impact on others.

The editorial team always appreciate your feedback on the content of each edition, and you may wish to do so via JHCC@hospitalchaplain.com. In particular, can I draw your attention to our appeal for more book reviewers? We have a backlog of books awaiting review – hence the reduced number in this edition – and you do get to keep the book you volunteer for!

With warmest regards,

Simon Harrison
Devon
October 2006

ON BEING A HEALTHCARE CHAPLAIN – PROPHETIC, POLITICAL AND PROFESSIONAL

Revd Peter Ellmore is Lead Chaplain for the South on the NHS Caring for the Spirit Strategy

Abstract

The complexity of relationship in which NHS healthcare chaplains exist can easily be underestimated. The author suggests that claims to prophetic or political insight, advocacy for a particular group, should be held in the context of the narrative of the local health community. The quest for a professional status by healthcare chaplains also needs to be tempered by the limitations of pre-existing allegiances and alliances held by the Chaplain and founded on contractual duty and vocational promise. A depth relationship is demanded of the healthcare Chaplain as a critical friend of all. This article gathers insight from Wilson (1970), Woodward (2001) and Swinton *et al* (2006) on being the Chaplain and being professional. It considers the difference between the prophetic and the political voices in a contemporary pluralistic society. It suggests a positive engagement for the Chaplain by which these voices may be heard in a local context. It offers a way to be that is prophetic, political and professional as a critical friend of all.

Main Article

Introduction

Some recently published articles examine or raise questions about the Chaplain's relationship with the patient, the medical profession, NHS management or their faith community (e.g. Newell, 2005,p.37; Swift, 2006,p.57). This article re-examines the Chaplain's place in the hospital and the network of relationship that they inhabit. It proposes a way of being that is critically proactive, aware of NHS policy levers and drivers and attempts to work creatively with change in the interests of the whole community.

Chaplains describe their work as the spiritual, pastoral and religious care of patients and staff. Many also claim a prophetic role to their work. Chaplains work within the tensions of many relationships. The impact of the modernization process of the NHS has brought its own stress into those networks. For example, the need for Trusts to tighten budgets and balance their books threatens redundancy to support staff as resources are diverted to 'front-line' services. Chaplains are not regarded by management as a core healthcare service and therefore they can feel undervalued and marginalized as redundancy becomes reality for some. They can find themselves set against NHS management aims. It is a useful time to re-examine the relationships between the prophetic and political in the pluralistic democracy in which we all live. As chaplains we need to be aware of the complexity of our relationship and ask what it is that makes us professional in our own

context. Firstly, is it important to establish our own ground for being and to ask ourselves the questions, to whom do chaplains belong and what are they for?

To whom do chaplains belong and what are they for?

The answer to the question posed is simple at first sight. NHS healthcare chaplains are employed (in most cases in England) by an NHS Trust under a contract. They are qualified for their work by training as a faith minister and subsequently authorized by their faith group (in most cases in England) to work in the sector ministry of healthcare Chaplaincy. Their work is well described by the occupational standards – the Health Care Chaplaincy Standards (CHCC 1993). There, however, the simplicity ceases. The work and role of the hospital Chaplain is contextual. Relationships are particular as well as official. Chaplains acquire skills and knowledge pertinent to their particular area of work. It is these three factors of context, personality and ability that make for complexity in the Chaplain's accountability, role and work. Specialist skills and unique context of work both point toward a need for chaplains to possess a status comparable with that of other healthcare disciplines allied to medicine. There is a desire for membership of a professional association that is recognized by, or allied to, medicine. Membership of a professional association, though, brings an additional strand of relationship. It broadens further the Chaplain's networks and thinking, but at the same time raises the question: Is there a pecking order to a Chaplain's relationships and can any one of them be held above or without reference to others?

Wilson (1970), in his study of hospital Chaplaincy, gives a very comprehensive analysis of both the primary task of the hospital as well as the role of the hospital Chaplain within it. It is instructive to this debate since, in spite of its date and context, it carries much of the essence of what Chaplaincy is and what it entails. It points to an alternative response to that outlined by Swift and Newell to the question of the Chaplain's stance towards a prophetic and political agenda.

Wilson concludes his study by the observation that:

The hospital Chaplain, like all members of hospital staff, has to work extemporaneously. He has many different roles and needs to be able to slip from one role to another with ease ... He experiences the tension of holding together professional and private life, formal and informal behaviour, relationship between skilled givers and passive receivers. In all his roles ... (prophet, priest, administrator, counsellor, teacher, evangelist, judge, servant, healer, friend, (p.91)) ... he is to be the same person ... The man who sets out consistently to be himself, enables others to be themselves (p.142). The Chaplain is to be him/herself whilst being available to all people ... (p.58).

He pointed to the tensions that exist, the need to win relationships and earn the respect of the staff of the hospital, a work that was easier for the whole-time Chaplain than for the part-time colleague. In this respect the Chaplain can be likened to today's, so called, 'portfolio worker', that is, one who has many skills to offer, has many associations with different organizations but belongs to no one. The portfolio worker is also their own person.

Chaplains may carry a portfolio of knowledge and skills but they delude themselves if they think that the associations they make are theirs alone. They act, and are being, in the name of their authorizing faith body as well as the NHS Trust that employs them. For the Christian, they are themselves identified and marked by their baptism; they belong to Christ. Wilson (1970, p.141) writes: 'There are two dimensions of a Chaplain's work. Firstly, he is a man (or a woman – mine) ordained by his Church for particular tasks within his own Church community. Secondly, he is also at the service of staff, patients and their families regardless of creed' ... The Chaplain belongs to the context of the faith community as well as the hospital. A Chaplain is not a shaman, a free spirit, a charismatic healer or prophet in their own right but is bound by promise, duty and contract. For most, that state is freely entered into after much preparation and conscience searching, an act of will and it need not be an abusive power relationship as described by Swift (2006, p.57).

More recent research in the NHS in Scotland by Swinton *et al* (2006) points to the fact that: 'One of the key questions that chaplains have to tackle is the issue of what healthcare Chaplaincy actually is in the midst of the cultural, professional and spiritual changes and transition that are taking place' (p.164). Some of their conclusions indicate that 'chaplains have begun to model a new way of being spiritual ...' (p.187). They are 'needs led' in their work and their way of being is determined not so much by their Christian theology or origins but by being 'Christlike', mirroring an agenda of 'secular humanism as it is communicated to the Chaplain in the pastoral encounter' (p.190). Relationship of pastoral encounter is crucial to the Chaplain's work and it can be determining of their way of being as well as what they do. A Chaplain, though, needs to maintain integrity within all of their relationships, to be a person, as Wilson (1970, p.142) pointed out who, whilst seeking 'to be consistently himself, enables others to be themselves.' A Chaplain's way of being, though complex, ought to be transparent to all.

The prophetic and political roles of the Chaplain

The Chaplain's relationships with their faith group and NHS Trust imply duties and promises and they are multi-directional as Wilson observes: 'Because he is appointed to the hospital, he has access to every department, and every level of the hierarchy. He can see the life of the hospital as a whole' (Wilson, 1970, p.141).

The Chaplain, like other Christians, is in conflict with the assumptions which underlie the life and work of the hospital. He must be aware how a doctor's frame of reference differs ... an individual pastor to individual patients, he is also Chaplain to the institution as a whole ... healing the sick is not just a matter of individual compassion but of justice and human rights ... (p.91)

It is this unique dual role that does set chaplains singularly apart but brings with it professional responsibility. It is the latter that can be impetus for the exercise of a prophetic role 'for the well-being of the hospital'. He goes further to comment that:

... we should certainly see this as work for the Church: but not through a Chaplain so much as through the Christian laity who are involved already in hospital planning and the power structures of the Health Service. (p.109)

Wilson perceives the potential for conflict within the role of the Chaplain when it slips from pastoral to include the prophetic in a politicized sense. It is this latter point that is at the root of much current debate. How can chaplains be pastoral, prophetic and political and hold fidelity in all of their relationships? I believe that we need to consider the role of prophecy and the way of politics to answer that conundrum.

Wilson's view is mirrored by Valley (1998) but within the context of the present-day pluralistic society. Prophetic statements are limited. They are made to guide and enlighten the faith group membership in their life and work in the world of democracy where people are free to exercise choice. A problem in a pluralistic democracy is that individuals' choice need not be informed by faith. A relativistic view is common. Even if some members of the democracy possess a prophetic revelation, different faiths may well offer divergent views giving rise to many different political outcomes to a single issue. This is especially true of views on matters of life and death. Prophetic insight may clash with the democratic outcome. 'When even the right to life, from conception to its natural end, is not fully respected as an absolute inalienable right, democracy is undermined and the formal rules for participation become an alibi that conceals the tyranny of the strong over the weak' (Valley, 1998, p.137). That observation by Valley is a faith-based statement, but it represents the view of a marginalized minority in the democracy. In the democracy all are called to live by their truth. That truth is not absolute but relative to their context. Abuse of power exists within the democratic process. In democracy the power exercised by an elected government or minister can be abused. When it is, it is something to be protested. However, in such circumstances it is the democratic process rather than the prophetic voice that is called to the work of protest. The secular voices of the media may also act as a form of prophecy expounding their own ideologies. They can also be used as part of the democratic voice in a political sense but their truths are partial. The hospital is a place of truth, according to the title of Wilson's thesis. The place for the prophetic voice to proclaim truth is the pulpit, the teaching chair for the faith community. It may come from the lips of the prophet in their conversations as the critical friend of those they meet. It may be revealed through the unfolding acts of the drama or crisis to which a Chaplain is called. Though such words may have universal application they will tend to be couched in the context of a particular world view held by the Chaplain. They are relative. They will be received only if that view has relevance to the listener. The political process, on the other hand, is exercised at the ballot box and in parliament to serve the interests of the whole community.

There are alternative ways of being as a Chaplain. Wilson's views are wholly Christian and assume a Christianized society where significant troops could engage with 'the principalities and powers' (1970, p.108). So how does it translate into the post-modern NHS in 2006 set within a secular administration in a pluralistic society? We are involved in a 'process world and universe', as David Jenkins (2004, p.177) in his essay on church leadership puts it. Great changes are about us and we all need to understand their significance and their purpose. The prophetic voice 'has to realize that revelation is not a print-out from the divine computer. It is all to do with a process pursued and sustained by the divine compassion and presence ...' (Jenkins, 2004, p.182.f). The prophetic voice of

the Chaplain when it is used has to be context specific if it is to be heard. It is used within the local trusted relationship and it reflects the story of that place. Swift (2006, p.61) makes the bald statement that 'Chaplaincy has no history'. Hospitals do though and their chaplains within them are still expected to be custodians, interpreters and bearers of some of that local narrative. It is when the prophetic voice is used to recall that, in the form of 'a protest rooted in tradition which has been forgotten,' (Leech, 1990, p.113), that it will be heard. It addresses the situation in the language of the local 'street theology', (Leech, 1990, p.115), rather than uprooted dogmatic statements from a particular religious or secular source.

Whilst the prophetic has its application in the local, the truths contained in the process of revelation also require a universalizing approach and response to change that includes all and does not separate out one party from another. The process is one that includes partners and those not like us. Government policy can and is informed by the actions and lives of all faiths and none, individuals and all peoples. Chaplains, too, in the NHS have been and are invited to be part of the change process, collaboratively sharing and acquiring a new revelation for healthcare. The collaboration, though, is in partnerships with all interested disciplines in healthcare, professionals, chaplains, management, churches, faith communities, secular communities and so on.

A concept of Chaplaincy as a community and profession defined by marginalization as well as non-negotiable value and knowledge set (self-defining CPD (Swift, 2006, p.60)) sits outside the democratic process. When chaplains become politicized, united in single and moral political protest, based in a spiritual gnosis, taking a particular side, then they are in danger of setting themselves up as a sect. They also imperil the very relationships that they need to accomplish their work. Chaplains need to stay connected with all and to be the critical friend of all. (That is also something expressed by Newell as he witnesses the internal struggle to remain open to all.) It is the concept of the 'critical friend', though, that enables the prophetic voice to be heard in the context of the hospital communities. When relationships are established by pastoral means then it is possible to become a critical friend. This is why the person and presence of the Chaplain is so important. It is not an overt political role but one that speaks the truth as perceived in the light of the narrative of the community to open the eyes of those that are blind to the consequences of their actions and to begin conversations that may change things for the good of all.

Chaplain as a professional

The impetus towards the professional status of chaplains in healthcare is well mapped by Woodward (2001). He has identified a number of characteristics associated with profession that Chaplaincy is developing, viz. a defined skill set, professional status, social closure and social control. Skills and outcomes seen in the Health Care Chaplaincy Standards (CHCC 1993) naturally lead to the management of a Chaplain's competency. A quest to seek statutory regulation can be seen as an attempt to seek social closure and professional domination. Status attained within the allied health professionals grouping would bring about elements of social control as well as subordination to the medical

profession. Against this, one of the problems that has beset chaplains and continues to do so is a clear understanding of the boundaries of their work. Much of the Chaplain's traditional work has migrated to more specialized elements of other healthcare professionals in the recent past. As an example, the role as advocate for the troubled patient is now largely absorbed by hospital Patient Advice and Liaison Services (PALS). The role of spiritual assessor of the patient is claimed by nurses (The Nursing & Midwifery Council (NMF) 2004). The listening ear of the Chaplain is now to be found attached to the counsellor. In a scientific and therapeutically orientated organization the Chaplain is assessed by what they do. Just what is it that chaplains do, is a perennial question that has never been answered satisfactorily. Swinton *et al* (2006, pp.164 and 189) has pointed to a role migration as chaplains effectively work by marketing their role as spiritual carer. It is a role that, whilst seeking to be spiritually neutral and caring for 'all faiths and none', lacks definition (Swinton *et al* 2006, p.186). Until some unique and defined territory can be determined for chaplains and agreed by other healthcare professionals then it is not clear what constitutes the profession of a health-care Chaplain. A profession is also more than a grouping of chaplains sharing 'a common experience of marginalized and exclusion' (Swift, 2006, p.61). Woodward also shows that clergy lack the qualities required to ascribe a professional status to them. He identifies 'issues of career structure, body of professional knowledge and employment practices', presenting ambiguities (2001, p.89). Chaplains are an identified but small group within the NHS healthcare system and in many of these respects are underdeveloped. Their counterparts in other countries (e.g. USA) have developed more of the professional traits but have accomplished that against a background that is far more accepting, less pluralistic and firmer in its religious convictions.

To act as a professional is another matter. Chaplains are called to be professional in attitude. In Woodward, 'to be unprofessional is to behave incompetently, unethically, inefficiently or even fraudulently' (Woodward, 2001, p.84). In that sense chaplains should always be professional and altruistic in all their relationships. The use of management methods, such as those encountered in the NHS and found within the Caring for the Spirit Strategy, for example, represents professional good practice. There can be a kneejerk reaction against the concept of management and ministry. Claims are often made that ministry cannot be measured, is of a spiritual dimension and therefore cannot be quantified by pie charts and time sheets. It is not subject for research either. However, a theology of work, economy and ecology is more positive. Good stewardship of our human, God given, resources, demands that they be managed efficiently. When they are, then there are also positive advantages to be gained. Management tools, therefore, are employed to enhance the ministry and not to control it. They can reveal where chaplains may be most usefully employed and indicate who is in most need. They can reveal and bring clarity to those who need to know just what chaplains are doing with their time. They may enable those whom chaplains work for to work with them in planning and best care for the staff and patients that they all attempt to serve.

Some Conclusions – Being a Chaplain: prophetic, political and professional

Governments and economic cycles trouble the NHS. They probably always will, just as the poor and the sick will also be with us. The present circumstances of change and restraint naturally challenge chaplains. In a pluralistic society their value set and world view can be different and apart from that held by the politicians, the professionals and the managers. That is no bad thing as it renders to them a unique role opportunity. They are able to offer an objective view as a critical friend to those they meet in their work. It can be a prophetic role, but because they hold a value set and world view that is usually faith based, they can be easily misunderstood, feel marginalized and set apart from others involved in healthcare whose vision is informed by science. In these circumstances, what should be the Chaplain's right response to policy and politics? Do chaplains, as Newell suggests, really belong to any one side or are they, as Swift claims, a profession defined by marginalization and exclusion? Extreme caution should be exercised before taking sides, for those who are then not for us must become against us. A polarized position and an agenda may inhibit the liberating role of the Chaplain from one side or the other. That may be necessary at the extreme, but is that the politic suitable for the Chaplain in the NHS in the year 2006?

Policy is informed by the actions and lives of all faiths and none. Chaplains in the NHS have been and are invited to be part of the change process, collaboratively sharing and acquiring a new revelation for healthcare. The model of healthcare perceived by the government is one that is scientific, and orientated towards the economics of consumerism. It tends to marginalize holistic views and alternative non-science-based therapies. It is individualistic. It is the model, however, that has developed and in which chaplains find themselves at work. In existential terms chaplains have a choice in the way that they want to be. The way of exclusion is one of those choices. Inclusion is the other, but it demands a proactive stance and readiness to enter into the initiatives and policies that are driving change within the NHS. Government policies may sometimes challenge deeply held convictions, but not all are bad. They are, in fact, the drivers and levers that enable change and can and are used to the advantage of the patient groups. They can also serve the interests of chaplains and spiritual healthcare. The NHS Caring for the Spirit Strategy should be understood in these terms. Chaplains have been invited to participate in change. The area Chaplaincy collaborative networks that have been established under the implementation programme of the Caring for the Spirit Strategy are strategic. They are specific to needs of chaplains and the needs of local healthcare economy whilst remaining true to the principles of the Strategy.

A greater awareness of healthcare policy could be enabling to chaplains who feel marginalized. Firstly it serves to provide knowledge of the background to the local picture of healthcare in which chaplains are working. That brings greater understanding of the influences determining local trends. Secondly, much government policy that emerges through the Department of Health is directed at local policy makers, the NHS Trust boards. It often contains great detail that can easily be overlooked by them. Some of the detail can be of use in establishing the Chaplain's *raison d'être*. Several themes related to Chaplaincy run through many policies. For example, the themes of patient experience,

quality, privacy, dignity, diversity and human rights are just a few. They pepper policies such as the National Service Frameworks that have been developed since 1998, specifically, the NHS Cancer Plan (2000), and spiritual support; Mental Health (1998), standard 7 for older people (2004); Older People (2001) and recent additions regarding Dignity in Care (2006); Long-Term Conditions, e.g. Palliative Care (2005) and Children (2004). The Essence of Care (2003 and 2006) contains elements of privacy and dignity in terms of the patient's personal world and personal identity, which includes religious observance and spiritual needs. The NHS Improvement Plan (June 2004) has expanded to include Creating a Patient Led NHS (March 2005), Commissioning a Patient Led NHS (July 2005) and the NHS in England, the operating framework for 2006/7. In addition to these there is the known guidance for NHS Chaplaincy: Meeting the Religious and the Spiritual Needs of Patients and Staff (November 2003). All of these and more can be viewed via the Department of Health website:

<<http://www.dh.gov.uk/PolicyAndGuidance/fs/en>>. The NHS Caring for the Spirit Strategy for Chaplaincy is also to be found via NHS Yorks. and the Humber at:
<<http://www.southyorkshire.nhs.uk/Chaplaincy/index.htm>>.

The NHS Caring for the Spirit Strategy was born in response to the NHS Plan of 2000 as part of a workforce reform programme for the whole NHS. It has its roots in policy and needs to be understood in that light. As the Strategy is implemented some chaplains are beginning to discover the positive advantage of working collaboratively together with others engaged in healthcare, gaining new insights and knowledge, informing their practice to enable change to traditional services. By this work they are becoming more clearly understood and included in the process.

That list of NHS policy is no insurance that will prevent the tide of change hitting Chaplaincy. It does not represent an attitude of going with the flow either. Familiarization and engagement with policy detail, though, could actually be a method of harnessing the natural forces that are driving change. In collaboration and at the local level, they can be used to reposition Chaplaincy within modernized healthcare and aid in defining the role of the Chaplain to managers and other health professionals. A secular-minded, materialistic, utilitarian management agenda will always seek ways to be rid of irrelevant overheads. Chaplaincy that is truly prophetic, political and professional and moving with the times will, though, be seen as an asset to be treasured.

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EXPLORING ASSUMPTIONS IN MENTAL HEALTH CHAPLAINCY

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The following is taken from a keynote address by Robin McGlashan at this year's Mental Health Chaplains Conference (Nottingham – 18th-20th September 2006), which looked at the theme 'Do you believe what I think you believe? Assumptions about theology and psychology in mental health Chaplaincy.'

In September 1963, I set sail from Southampton on board the P&O liner *Chusan*, to take up a post as a teacher in a seminary in the Church of South India. Many Christians had made a similar voyage before me. Perhaps the first were the Syrian Christians from the Persian Gulf area in the third century, who had settled along the south western coast of the peninsula. In the succeeding centuries, they assumed a place as a distinctive, separate community within the hierarchical caste structure of Indian society. The next wave were the Jesuits, following in the wake of the Portuguese. Francis Xavier worked among the fisher folk around the southern coasts in the 1540s, and Robert de Nobili settled in the city of Madurai in 1605. There he adopted Brahmin dress, food, social customs and taboos, and effectively became a Brahmin among the Brahmins. The first Protestant missionary was Bartholomew Ziegenbalg, a German Lutheran sent by the King of Denmark in 1706 to the Danish settlement of Tranquebar on the Coromandel coast. Held at arms length both by the Danish administrators and the Roman Catholics, he learnt Tamil from the urchins sitting in the dusty streets of the town.

Each of these groups had their own strategy for evangelization, based on their different theological presuppositions. In general, the Roman Catholics adopted many of the social customs and (suitably adapted) religious rituals of Hinduism. For example, like the Hindus they celebrated 'car festivals', in which images of saints or deities were drawn through the streets on elaborate wooden chariots amid public acclaim and veneration. The Protestants on the other hand sought to preserve and emphasize the difference between themselves and the surrounding Hindu society, to the extent that my first Tamil teacher, himself a high-caste Hindu, used scornfully to say that the Catholics were just like Hindus, and the Protestants just like Europeans. In succeeding generations, among such differing approaches every new missionary had to find his/her own place to stand, and work out of it with confidence and consistency.

The point of this brief excursus into Indian church history is that every Chaplain who is appointed to work in the mental health service will also find him/herself entering a new world with its own assumptions, values and ways of doing things, which is not like anything s/he has ever met before. Armed with the panoply of modern science, psychiatry itself enjoys great prestige and power. In addition, psychiatric institutions are

awash with the tidal flow of unconscious forces generated by the concentration of mental illness which those institutions contain. New chaplains can easily be overawed by all this, and feel themselves de-skilled and lacking in the tools and confidence to contribute to the healing task in which they are called to participate. What may be happening here is that the Chaplain may come to carry the weakness and impotence which belongs to the institution, in the face of the intractability of much mental illness, and which the institution itself cannot fully allow into consciousness. So it is denied, relegated to the institution's shadow, the psychic repository of all that it cannot, or does not want to, own about itself. Paul seems to have known about this kind of polarizing mechanism in his relationship with the Corinthians, and he found it particularly uncomfortable to be left carrying their shadow: 'We are fools for Christ's sake, but you are wise in Christ. We are weak but you are strong. You are held in honour, but we in disrepute' (I Cor. 4.10).

This impotence which chaplains sometimes experience does not wholly belong to them, but it can leave them under strong pressure to escape from its discomfort, or to defend themselves against it. This they can do in a variety of ways. One is to withdraw from the life of the institution into the circumscribed area of their own religious/ritual functioning with receptive individuals, where they feel safer and more competent. Another is to seek for some competence and recognition among their colleagues of other disciplines by acquiring relevant non-theological skills or qualifications, perhaps in the field of counselling or psychotherapy. If the specific Chaplaincy task is thereby neglected or disparaged, this identification with the ethos of the institution can amount to 'going native', like de Nobili among the Brahmins in seventeenth-century Madurai.

These different reactions to the pressure of the environment can be a source of tension between Chaplaincy colleagues. On the one hand, those who stick exclusively to the explicitly religious task can view their more psychologically inclined fellows as having 'sold the pass', or as 'having no gospel', while the latter group can regard the former as naive, irrelevant and marginalized. There is ample opportunity here for the kind of mutual suspicion and contempt which divided the Pauline churches over such matters as the observance of special feast days and the eating of meat offered to idols (Rom. 14; I Cor. 8, 10). Here too there were varying opinions about how to relate to the environment, often experienced as hostile, whether Jewish or pagan. The 'conservatives' kept strictly to the traditional observances in these matters, and strongly disapproved of the licence exercised by the 'liberals', while the latter despised the former and claimed freedom from such scrupulous restrictions. Paul's advice was that all equally are servants of the one master, and will give account to him: 'Why do you pass judgement on your brother? Or you, why do you despise your brother? For we shall all stand before the judgement seat of God. (Rom. 14.10)

Assumption One: to be a Chaplain properly, there is only one way to do things, just as the Romans and Corinthians thought that there is only one way to be a proper Christian; all have to do and to believe the same; there is no room for diversity.

What can be the ground of such an assumption? It ignores the inherent diversity among human beings and the variety of gifts with which we are endowed. In matters of belief, even if we were to use the same words, it is clear that we would not all mean the same thing by them. And why, anyway, should there be thought to be a need for such uniformity? It seems to spring from the position of my not being sure, and needing you by your agreement to confirm that I am OK, and not to be blamed for being wrong. I need to be right, and to feel superior, and your agreement supports that. However, if you disagree, then I lose control, and the fear of chaos supervenes, in which all way marks will be lost. I am left alone and vulnerable. Therefore, I cannot allow important others to differ from me. If unimportant people differ from me, that is another story; that simply allows me to congratulate myself at their expense. In fact, I personally am more interested in understanding other people, even (or especially) when they use the same form of words as I do, or apparently operate in the same way, than in imposing on everyone some Procrustean uniformity.

Related to this assumption that everyone has to do things in the same way is the question that apparently arose in a discussion among chaplains: 'Why can't I answer the patient's question directly?' This seems to assume that some Chaplain(s), trained in counselling perhaps, were suggesting that you should never do such a thing as give a straight answer in such a situation. My answer to this would be twofold: 1) Do you know what the patient is really asking, or not asking, but affirming? What does the question really mean? It seems to me to be a mistake to assume that we know. Understanding the question depends on close attention to the whole person, within their personal and social context, and within the relationship with the Chaplain addressed. When the question has been properly understood, then perhaps it can be answered. 2) And what does this question (why can't I answer the patient's question directly?) really mean? At one level I would suggest that it expresses some resentment: 'Who do you think you are, telling me what to do!' But it also assumes the existence of some external authority, and acknowledges its right to prescribe what can and what cannot be done, and so to inhibit me from acting autonomously.

This touches on a central issue for chaplains: How do I discover my own self-directing authority in ministry? We need to develop enough confidence in ourselves to know where we stand and to minister consistently out of that place. That would enable us to enter open dialogue with others, to put ourselves at risk, to face awkward questions, to be challenged, even humiliated or shown up, and so to gain enrichment from the new perspectives and insights which that might yield. To new Christians trying to navigate their way through the competing demands of the old ways and the new in the first-century Mediterranean world, Paul offered the advice: 'One man esteems one day as better than another, while another man esteems all days alike. Let everyone be fully convinced in his own mind' (Rom. 14.5). But how to come to this conviction? I cannot set out a fool-proof behavioural programme to achieve this, but I want to spend the remainder of this paper thinking around this question, using the analogy of cross-cultural mission with which I began.

1) Language study

My first 18 months in India were spent in language study and orientation, before I ever set foot inside a classroom to teach. I had not only to speak and understand the local language, but also to become familiar with and to understand the culture. There is a whole new language and culture awaiting the newly appointed Chaplain in the mental health service too. S/he has to become familiar with the rules pertaining to locked wards, to patients' notes and confidentiality, with the interior world of depressed and psychotic patients, and much, much else besides. This initial phase is crucial, because at this time the new Chaplain is especially vulnerable and impressionable. There are opportunities for learning at this point which may not recur, because s/he will now see with fresh eyes things which subsequently will not be noticed. Questions will be raised, mistakes made and patterns formed that may last throughout his/her service. So at this stage there is an essential need for support and shared reflection. Thus, in 1977, when I joined the staff at West Park Hospital, Epsom, I was fortunate to be one of five full-time chaplains in neighbouring mental illness and mental handicap hospitals within a stone's throw. We used to meet for lunch once a fortnight. Then there was the late lamented Guildford and Southwark Diocesan Psychiatric Hospitals Chaplains Fellowship, familiarly known as the Gilbert and Sullivan, which met regularly every couple of months or so. And at that time through the training department of the SW Thames Regional Health Authority we set up a mentoring scheme for newly appointed Chaplains, which also has failed to survive. None of this amounted to supervision in the strict sense, but all these were means which helped me personally and a good many others to survive and to learn in the new environment.

Assumption Two: study and knowledge of academic theology are in themselves sufficient preparation for pastoral ministry.

This assumption is instilled by the way that our theological education is structured and conducted. For myself, after my first degree at Oxford, I went to Cambridge to do a theology degree, and so was 'let off' with just one year at theological college, of which six months were spent at the World Council of Churches study centre in Switzerland. And in the remaining six months, my practical training consisted of going out to villages in the fens on a Sunday to take services and to preach, without any structured opportunity to reflect on that experience or any systematic formation in the skills of listening and pastoral conversation. Nor was any serious attention given to personal problems or to issues of personal growth. I know of at least five of my contemporaries who needed professional help for psychological difficulties within two years of ordination. The only thing that I remember from the last address given by our dearly beloved principal, the late Cyril Bowles, to the final year students before we left, was the advice on how to eat green peas with a fork! That was over 40 years ago, but are things so different today? I understand that in three years' study on the Southwark Ordination Course, a student was required to do no more than 30 hours on a practical placement (that is less than one hour a month!), and that the recent Hinde report on theological education recommends that even more emphasis be given to academic preparation.

What needs to happen in our theological education is that from the very outset we be trained to learn from experience. In my view, habits of systematic reflection on pastoral practice have to be instilled as part of the college programme. Then, when the pastor is first appointed to the mental health service, in that crucial early phase the first thing that s/he will naturally do as a matter of urgency is to find a supervisor, someone who is skilled, sensitive and experienced, with whom s/he can meet regularly for support and reflection.

Here is a working definition: 'pastoral supervision is a method of doing and reflecting on the ministry in which a teacher (supervisor) and one or more supervisees (learners) covenant together to reflect critically on their ministry as a way of growing in self-awareness, professional competence, theological understanding and Christian commitment' (Pohly, 1977, p.64). This is essentially a reflective process, which means that the focus is primarily on work done and experience gained; its main focus is not on planning and arranging for work to be done in the future, like management. And it is a shared process, in which the supervisee discloses the truth of his pastoral practice to another, what actually happened in the pastoral encounter. If that has never been experienced before, it can sound daunting enough. But mention of the verbatim as the classical instrument of supervision may well sound even more frightening, and can arouse the stoutest resistance. However, to reflect critically does not mean to hand out criticism or blame, but to look closely at, to look below the surface, to discern, to see from a new perspective. This process may, in fact, release the supervisee from blame, either of him/herself or of others, rather than reinforcing it, by giving rise to new understanding of the patient and new insight into his/her own reactions.

2) Translation

In 1714, eight years after Ziegenbalg arrived at Tranquebar, his ground-breaking translation of the New Testament into Tamil was completed, the first translation of any part of the Bible into a non-European language since the early centuries of the Christian era. I was myself privileged to be a member of the Tamil New Testament review committee in the 1960s and 1970s. This work of translation involves moving not only between two languages, but between two worlds – in the case of the psychiatric Chaplain the world of science and human experience described in psychological terms and the world of theology, revelation and tradition. It is important to note that according to Pohly's definition quoted above, supervision should stimulate this process by encouraging both self-awareness and theological understanding. Thus, our theological baggage becomes earthed in concrete, inter-personal experience.

Let us look at an example of pastoral supervision in which this kind of translation process took place. I was supervising an Irish Roman Catholic seminarian on his placement as a student Chaplain in an acute general hospital. He reported on his conversation with a seriously ill patient, who was clearly a devout Evangelical Christian. The patient affirmed cheerfully that he was OK, that he trusted in Christ and that Christ would look after him, with an unwavering and unassailable consistency. The Chaplain felt held at arm's length, disarmed and powerless, unable to make contact with the patient's humanity. He came to the depressing conclusion that he had failed. In our supervisory

session, we reached the psychological understanding that the patient was in the grip of a splitting process: consciously he felt strong and buoyant and OK, while all his feelings of weakness and fear were repressed and consigned to the unconscious. In the Chaplain's experience of powerlessness and failure, he was experiencing what the patient denied. In psycho-analytical jargon, his sense of failure was his counter-transference induced by the patient's projective identification.

However, in our supervision together we did not stop there. We looked at the place of doubt and struggle and failure in the Christian life in the light of the Christian tradition, where it is seen as inevitable, necessary indeed, as an expression of our humanity, but also the place where we meet with God's understanding and compassion. But in the patient's spirituality, the myth of the 'victorious life' had reinforced his instinctual defences against anxiety, to the exclusion of the Pauline paradigm of God's grace as all-sufficient and his strength as made perfect in weakness (II Cor. 12.9). As a result of our conversation the student was enabled to recognize what had been going on in his encounter with the patient, and so to minister to him with patience, simply making himself available and waiting for such a time as the patient might be able to make use of the relationship.

Assumption Three: only counsellors and psychotherapists can do the real work of mental health Chaplaincy, therefore all aspiring chaplains must train in that field; unless you master those skills and that language, you will remain incompetent as a Chaplain. It may be further assumed that, even if you do not hold the above view yourself, others may hold it about you if you are not psychologically trained.

I personally do not subscribe to that view, not because such training is irrelevant or unhelpful, but because it is not enough. What I have been advocating here is not the ability to operate as a professional in one specific treatment approach, but the ability to understand and be at home with the discourse of the psychiatric environment. Moreover, what the Chaplain needs is fluency in a language that is adequate to describe the depths and vagaries of human experience even in its most extreme forms, from wherever that language is derived, and such fluency can only be based on the readiness to explore the depths of his/her own experience. In addition, for those who do acquire a formal psychological training, there is always the temptation to ground their standing within the multi-disciplinary mental health team on that proficiency rather than on their core professional identity, which is as the bearer and representative of a distinctive religious tradition, which has its own contribution to make to the therapeutic endeavour. So it may represent a flight from the felt incompetence and weakness of the Chaplain's role, a kind of 'going native' in the style of Robert de Nobili.

3) Integration

When you live for any length of time in a Tamil-speaking environment, you begin to dream in Tamil, and Tamil ways of thinking and expression begin to come as second nature. The language and culture gets into one's bloodstream, so that one's whole outlook is infiltrated and enriched. Then the painstaking business of word-for-word translation from one language to another is transcended, and a measure of integration is attained. On a

broader scale, we can see this process at work throughout Christian history whenever the gospel has been carried into new cultures or faced with new challenges, as for example in the move out of the Jewish environment into the Hellenistic world in the first century, or in the conflict with the new scientific understanding of the world in the nineteenth. The understanding of the gospel has come to be shaped by each new context in which it has lived, and to integrate the rich new insights which that context offered.

So we each need to develop for ourselves a scheme that can comprehend and do justice to the world of modern psychological insight and experience that forms the context of our work. More than that, that context has to be allowed to enlarge and enrich our theological understanding. In fact, we need the challenge and stimulus of the 'alien' culture in order fully to understand ourselves and where we come from. In the words of the Roman Catholic monk who settled in the city where the Lord Krishna was born: 'Only in the dialogue does a Hindu learn the essence of Hinduism, and the Christian find the essence of Christianity' (Klostermaier, 1969, p.98). Of course, no one answer will fit all; each has to find his/her own path. But I would like to share one suggestion, which comes from my own experience in a slightly different corner of the territory, working with individual adults as an analyst.

I have come to see the path of Christian discipleship as essentially a process of growth in self-awareness. This view can be given a Biblical basis in Luke's gospel, where roughly half the recorded teaching of Jesus is presented as directed against the Pharisees, or as having arisen in the context of controversy with them. Now Jesus called the Pharisees 'hypocrites', that is to say 'actors', even 'white-washed tombs' (Matt. 23. 25f). That is to say, there was a discrepancy between their inner reality and their outward appearance. In Jungian terms, they lived by denial and projection of their shadow, and by carefully fostering the persona to the point where they were taken in by it. Their external behaviour, characterized by the rigid enforcement of rules and the condemnation of others' failure to conform, reflected a fierce internal battle to maintain the repression of all that they were not able to acknowledge about themselves.

It is this blindness that represents the wrong turning, the primary danger to spiritual life to which we are all to a greater or lesser extent prone. Jesus' condemnation of this stance implies a view of discipleship as growth in insight and self-awareness, a movement towards integration and wholeness, in which we become progressively more able to acknowledge and accept our own reality and the reality of others. In the words of the Psalmist: 'For lo, thou desirest truth in the inward part' (Ps. 51.6). Or as John Darrow says to Charles Ashworth, the upwardly mobile cleric in the first of Susan Howatch's *Starbridge* novels, when with his life in a mess he first comes for spiritual direction: 'High and wide is the gate which leads to self-deception and illusion, but for those seeking truth, strait is the gate and narrow the way, and brave is the man who can journey there' (Howatch, 1988, p.202). What makes this to be gospel, good news, is that it is set firmly within the context of God's grace. The further we go inward, the more we discover of God. Within that relationship, it becomes safe to let in the light, and to dismantle the defences we have relied on for so long.

All this has been an attempt to answer the question, how we can find the inner authority to minister in a strange environment with confidence, without being blown about by the expectations or demands of others. This search is of course the manifestation in a particular professional context of a universal developmental task, which faces every human being in their growth into adulthood. In the field of mental health Chaplaincy, I have suggested that three processes are involved – viz. language learning, translation and integration – which we have considered in the light of the parallel with more traditional cross-cultural mission experiences. This brings us to a final assumption.

Assumption Four: we can accomplish all this on our own, relying on our personal, direct access to God, without having to undergo the painful and sometimes humiliating process of learning in this highly personal and sensitive area with or from or through another human being.

When stated baldly like that, only a few perhaps would own it. But isolated, self-reliant ministry still seems to be the dominant pattern in the church. We have not learnt or experienced the immeasurable benefit of doing it in any other way. But as I have said earlier, some form of supervision or consultation is in my view essential for learning in the practical tasks we are engaged in. The number of colleagues who have gathered in this conference is testimony to the fact that many others too are looking for some form of support.

Besides suggesting some of the ways in which we may become our own persons in ministry, I have mentioned some of the assumptions that inhibit and restrict our functioning. In these days together, other such assumptions may float to the surface also. I trust that in this conference we may be able to examine them without mutual judgement or contempt, but with freedom and honesty, to our own personal benefit and to the benefit of those to whom we minister.

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EXPLORING YOUR SPIRITUAL SIDE

Emma Louis is Lead Chaplain/Co-ordinator of Spiritual Care at Sandwell Mental Health and Social Care Trust, **Nick Jones** is one of her colleagues, **Craig Green** is Head Occupational Therapist for Adult Services at the same Trust. **Hannah Patrick** is a Mental Health Service-User and Group Facilitator and **Simon Price** is a Community Group Worker for Sandwell Mind

Abstract

Exploring Your Spiritual Side was the name of a group run at a Day Centre at Sandwell Mental Health and Social Care Trust in the West Midlands. The original model for the group was then adapted and developed in different contexts. This article outlines the background to the groups and how they happened and also lets three different facilitators share their own experience and perspective on the group that they were involved with.

Keywords

Exploring, Spiritual, Group, Participants, Service users, Mental health, Journey, Hope, Resources

Main Article

Preparations for the Journey

Prior to December 2004, when I was appointed to Sandwell Mental Health Trust as Lead Chaplain, there was no formalized or structured Chaplaincy – Spiritual Care being offered within the Trust. I say no ‘formalized’ care because this didn’t mean that nothing was happening in this area! One of the joys for me was discovering pockets of good practice going on in the absence of official Chaplaincy-Spiritual Care and meeting people who cared deeply about this crucial element of healthcare.

One of those people was Craig Green, the Head Occupational Therapist for our Adult Services in Sandwell. Craig has worked within the Sandwell Mental Health Trust since 1997 and has a personal interest in spirituality through Buddhism. Like many practitioners, his awareness of spirituality began to influence his work. He began to understand people’s mental illness as a journey of self-discovery, learning and ultimately self-improvement. These qualities, along with hope, are a core part of the Recovery Model used within the area of mental health and adopted by the Sandwell Trust. Craig also worked with a nurse practitioner within the Day Hospital setting who led a ‘mindfulness for depression’ group (Segal *et al*, 2002). This provided a valuable insight into how spiritual practice can be used to deepen and influence a person’s recovery from

illness.

At the earliest opportunity Craig and I met together to share our common passions for exploring spirituality (he from his Buddhist background, me from a Christian background and both having a shared interest in meditation and mindfulness). We wanted to discuss what could be developed in the area of spiritual care within Adult Services and with the Chaplaincy-Spiritual Care Team and Occupational Therapists working together. Craig had been involved in an Occupational Therapy Journal Club earlier in the year where he'd presented two articles on spirituality. Several models of practice within Occupational Therapy make reference to a person's spirituality and beliefs, including the Canadian Model which views this dimension of a person's life as the core part of their being. As part of the literature review he discovered an article in the *Community Mental Health Journal* about a group which explored issues of spirituality and looked at the impact of spiritual resources on the well-being of those with mental health problems.

The article was entitled 'Development and implementation of a spiritual issues psycho-educational group for those with serious mental illness' (Phillips *et al* 2002). The group was semi-structured and ran for seven sessions. It was a closed group. Those who initiated the group approached spirituality in a very broad way. The group wasn't based in, and neither did it grow out of, any particular faith community context. Rather than being faith-focused it followed a more 'inclusive set of spiritual topics' (2002, p.488) including the participants sharing their own personal spiritual journeys, considering spiritual resources, spiritual struggles, forgiveness and hope. The group was 'designed to provide both new information about spirituality to participants and to allow them to share experiences and knowledge that they felt might be of value to others.' (2002, p.488)

Conclusions and recommendations included participants saying that they had 'enjoyed and appreciated the unique forum in which they could explore an area that is often neglected in the mental health services setting' (2002, p.493). They also liked 'hearing about others' spiritual beliefs and interests'. They felt 'listened to in a non-judgmental way and experienced a sense of connection among themselves as well as the facilitators'. (2002, p.493)

Embarking on the Way

The programme appeared particularly suitable for the service users within Sandwell so Craig and I adapted these ideas and created a six-session course which we trialled at Positive Choices – one of the Trust's Day Centres. The group was targeted at those who wished to explore their own spiritual journey and develop their sense of spiritual well-being. We agreed to facilitate it together.

Participants who we thought may be interested, or find the group beneficial, were invited to attend by Craig, the Day Centre staff or me. Others responded to our colourful publicity and were asked to express interest to their key worker. We described the group as:

an opportunity to explore your spiritual journey, sources of help and your hopes for

the future with others in a warm and supportive atmosphere. It also stated whatever your beliefs or spirituality ...

We held it in a comfortable room in the Day Centre and offered refreshments half-way through the hour and a half session. Eight people attended the group initially and six came on a regular basis. Of those six, three had a particular faith.

The aim for the group was:

for each individual to develop a greater understanding of their spiritual journey so far, spiritual resources available to them and their spiritual aspirations for the future.

Themes of sessions:

- My spiritual journey
- Spiritual resources
- Spiritual struggles
- Compassion and forgiveness
- Hoping and coping
- Reflecting on the journey – closing session.

We formed some objectives as follows:

- For each person to explore their spiritual or religious background and beliefs by regular attendance of a minimum of four of the six sessions.
- For each person to develop an increased understanding of their feelings, problems and questions that arise within their own spiritual context and be able to describe them to the group.
- For each person to develop an awareness of at least two internal and two external spiritual resources.
- For each person to be able to describe their understanding of the relationship between spirituality and well-being.
- For each person to be able to describe what it means to practice tolerance and respect for spiritual differences by session two.

Each session involved a recap on the previous week, a reminder of group 'rules', an introduction to the theme of the day, group discussion, a group exercise and time to reflect individually. We provided participants with a notebook to record questions or thoughts between weeks or to draw or write what they were feeling at the end of each session. Facilitators participated fully in the exercises and discussions.

Although there are currently various definitions of spirituality on the table, it is still a notion which is notoriously hard to define. For the purposes of the group we developed what might be called a generic definition of spirituality. We talked about it being to do with the things going on inside us, how we make sense of life and what 'makes us tick'. It could involve questions about meaning, values, hope, love and things beyond the

physical boundaries of life. We agreed that it could include reference to a particular faith/spiritual tradition but not necessarily so.

Here are some of the comments which participants shared in the final session:

We've only just got started, can this carry on? Could we visit some faith communities to learn more about other peoples' beliefs? Could we go on some trips out to the countryside to find some peace? The best thing has been the friendships; I feel less isolated and appreciated everyone's openness. I understand more about my spiritual journey now. It's been really interesting to hear other peoples' point of view. I feel hopeful again. I've learnt a hell of a lot. I have personal things to sort out but feel a lot more equipped.

We can supply details of the contents of each weekly session to those who may be interested. Although this group was run in a mental health setting we can also see the potential for this kind of dialogue or discussion in the acute or hospice setting. It could possibly be used as a resource for one-to-one encounters or as a tool for informal 'drop in' gatherings that might happen in a prayer room or faith centre. Maybe even with other staff ...?

The View from Different Angles

The following three personal perspectives from other facilitators of the group show how the idea has developed in different contexts within the mental health setting. Nick Jones shares his experience of adapting the model for an in-patient setting, Simon Price writes from a community angle about the group he runs in a local library. Hannah Patrick has the last word as a service-user who participated in the initial group and then agreed to co-facilitate the next one.

Nick Jones – Chaplain/Co-ordinator of Spiritual Care

Following the initial group sessions in Day Services, I joined Craig and Emma to look at the possibility of running the group at Hallam Street Hospital, an acute in-patient psychiatric unit for adults.

I was very impressed with the material and the way in which it had worked so far and was keen to see if it could work in a different context. Craig was keen for the Chaplaincy-Spiritual Care/Occupational Therapy partnership to continue so we planned the course together. We intended to run it in roughly the same format as the course in Day Services, with two less sessions and slightly less emphasis on some of the 'tougher issues', specifically 'spiritual struggles' and 'forgiveness'.

We quickly became aware of some changes that needed to be made for the group to work effectively in an in-patient mental health setting. Richard Taylor, Director of Nursing at the Trust and Chaplaincy Line Manager, gave two key pieces of advice that were to prove very helpful. Firstly, he reminded us of the work of Irvin Yalom, who recognized that running groups in an in-patient setting was completely different to an out-patient setting, and that a group designed for out-patients could not simply be transferred to the

in-patient setting (Yalom 1983). Secondly, that it is important to run such a group in a way that provides as many in-patients service-users as possible with an opportunity to access the course. He suggested that we were better off having a large number of people coming along to some sessions over a period of time, rather than having a neatly formed small group which might be inaccessible to many in-patient service-users. This is particularly relevant for those who, for various reasons, find it difficult to access the resources provided due to issues of concentration, restlessness, distractions of other activities or interventions and the physical layout of the buildings.

We therefore decided to run the course in three-weekly cycles. The first session focused upon 'spiritual journey', the second on 'hope' and the third on 'spiritual resources'. The group was open to all and we ran it in a room in the hospital Resource Centre (a different building to the residential houses). We quickly became aware that Yalom's analysis was accurate. Methods of ordered group work that had proved helpful in the out-patient setting were inappropriate with the in-patient group. Group participants would share remarkable insights into their spiritual lives but would struggle to keep to a neat systematic pattern of group work. Participants would sometimes appear to be distracted, restless or disinterested, but would then find their own way of engaging meaningfully with the session. There were quite a few comings and goings and the group often had a chaotic feel to it. Despite all this, Craig and I were thrilled with the depth of sharing that was facilitated through the group and the feedback received suggested that the group had been greatly appreciated by those who attended.

We decided that the most effective way to run the group was to construct a series of prompts relating to the particular session. We then used our group work skills to allow each participant to draw out deeper meaning from their reflections and enable the group as a whole to pursue presenting issues in the light of spiritual journey, hope and resource.

Over the course of nine weeks we ran the group three times, with different people coming each week. Some came to a whole three-week cycle, some to fewer sessions, some returning to sessions they had attended in the past. In all 23 service-users and six staff attended the course at some point in those first nine sessions. The next challenge was to make the course open to those who found it difficult to access resources. The layout at the unit means that those on a section or observation, or who have problems venturing outside, weren't able to access the course. We also wanted to reach those who rarely attended any activity provided. We approached the residential houses at the unit with the idea of running the course in the lounges of each house in turn. There are four houses each with 18 beds.

This was an extremely successful move as we are now able to fix a time that suits the particular house and enable people to come who find it difficult, or who are unwilling, to access groups in the Resource Centre. As hoped, the groups have attracted service-users who have no previous history of attending groups. We have also had four Occupational Therapists at different times who have helped to run the group or who have led it in the absence of the Chaplain. Other staff members, particularly nurses, have come along to

either participate or observe. The group has therefore been a very helpful tool in our attempt to mainstream and raise awareness of spiritual healthcare throughout the Trust.

We continue to reflect on how we can develop and improve the way in which we facilitate spiritual reflection through our group work at Hallam Street and look forward to the next stage of our journey which has been exhilarating so far.

Simon Price – Community Group Worker, Sandwell MIND

I have been facilitating a weekly spirituality discussion group called 'Exploring Perspectives' since May 2006 in West Bromwich library. In the Sandwell area of the West Midlands, MIND have moved away from the traditional 'day centre' model of mental healthcare towards a more community-based initiative through the establishment of the Community Group Work Project. The aim of the project is to reduce the stigma often associated with day centres and to involve a greater range of mental health sufferers than would ordinarily access a day centre service. The openness of the project's referral process has meant that already, since the beginnings of the Exploring Perspectives group, a diverse collection of people have met together to explore and discuss their spirituality and support each other in the struggles that they encounter.

My own interest in the link between spirituality and mental well-being began with a 'breakdown' suffered whilst studying Philosophy and Theology in 1998. During this time I keenly felt the dangers implicit in searching for 'the truth' by purely intellectual means, in isolation and cut off from both my feelings and those around me. Since this crisis I have continued to experience depressive episodes but one of the ways I cope is through dialogue with others and research into areas such as phenomenology and the writings of Nietzsche.

The Exploring Perspectives group that I am currently facilitating has a strong discussion base which we balance with trips to places of worship or natural beauty and involvement in creative and meditative exercises. The initial sessions of the group took the form of the six-week programme mentioned earlier in this article and were facilitated by the Lead Chaplain. I have then created a programme of themes and visits for the rest of the year. The group doesn't have a fixed membership or compulsory attendance. This will hopefully allow for a broad range of individuals to 'drop in' at different points.

One aim of the group is that people can come together under the umbrella of common and, according to Paul Tillich, 'ultimate' (Tillich 1952) concerns and shared struggles, to better strengthen and define their spirituality whilst also recognizing that we all have equally valid but diverse ways of expressing ourselves.

I am keen to encourage involvement from people wishing to develop both faith-based and secular spiritualities. It is for this reason that I attempt to use theoretical frameworks that are neutral and applicable to both. In some sessions on comparative religions I refer to Ninian Smart's 'dimensions of religion' (Smart 1989), a useful teaching tool for showing the shared dimensions of the six major faiths but equally applicable to more humanist belief systems. I have also found that Heidegger's 'dimensions of being' (Heidegger 1962) are a very good way of exploring essential facets of spirituality, namely being in the

world, being with others and being with self. These will be followed with sessions on freedom, coping with death and suffering and dealing with meaning.

I find that Reinhold Niebuhr's 'serenity prayer' (Ashwin, 1996, p.48) is a good reminder that we should focus equal efforts upon accepting our limitations and developing the strength necessary for this, and developing an awareness of the options available to us for furthering our spiritual journeys. This is the version of the prayer we used for group purposes:

*May I have the courage to change the things I can,
the serenity to accept those I cannot change;
and the wisdom to know the difference.*

It will hopefully be a lasting legacy in the lives and future journeys of those attending the group that they will be able to balance activity with passivity, control with submission and develop the 'courage to be' in what are often very troubling times.

Hannah Patrick – Service-User and Group Facilitator

After much distress in my life I suffered a 'nervous breakdown' in September 2005. Having had a faith for as long as I can remember, I felt lost and angry that God had let me down. I was constantly asking 'why me'?

In October 2005 I attended a day centre that was advertising an exploring spirituality group and felt I would go – after all I had nothing to lose. I felt lost anyway and saw no future for me. I had lost all hope, and hope was always what kept me going.

The group helped me to realise my faith was still present and the mixture of ideas and level of sharing between participants gave me an inner strength and confidence. Each person gave me encouragement and I hope I was able to give some back too!

After the group had ended I was asked if I would like to jointly facilitate a second group at another day centre. As always I agreed, leaving myself anxious because I never say no. I wondered what I had got myself into, I felt I was not ready, my depression sometimes leaves me drained, and to add to that my physical health, including mobility, was getting worse. As the time of the second group got closer I felt more and more that I could not cope with running a group, and I told myself this several times a day which just added to my fears. I felt anxious all the time. I had regular meetings with the other group facilitator who was the Lead Chaplain. I'd smile as we went through the arrangements for every weekly session in preparation, not showing my inner anxieties and probably giving the impression that everything was okay.

The day came to do the first session. My nerves and a sense of wanting to be physically sick soon went without me even noticing it. I felt that my fears were now totally unjustified and I worked better than I could ever have imagined. This made me feel better about myself and what I was able to do. Despite a few blips along the way, including me having a fall resulting in concussion, I grew stronger as the weeks progressed. My admiration for people in the group, who have gone through tremendous difficulties, increased my spiritual awareness, and as my knowledge of spirituality has

grown, my faith is stronger. Learning how other people cope has encouraged me. We learnt so much from each other that my hope came back.

I still occasionally suffer with depression and struggle daily with my physical health, but I am now at peace with myself. I know I have come so far that the future is not bleak anymore.

Thanks to all who contributed to that first exploring spirituality group. You have no idea how much you improved my life and my outlook of whatever comes my way. Here's to more exploring spirituality groups, so that more people can gain. I have asked to go and observe another of the groups in a different context with the view to facilitating that, then ...well who knows!

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¹Scottish Executive, *Spiritual Care in NHS Scotland HDL (76) 2002*

'CAN YOU HELP US TO HELP YOU?' TRAINING NEEDS ANALYSIS REPORT

Revd Alister Bull is Head of Chaplaincy Services, Yorkhill Division, Greater Glasgow Health Board

Abstract

The article addresses how the Scottish Executive agenda for Spiritual Care in the NHS Scotland requires a greater awareness of spiritual care by staff. It focuses on a training needs analysis that was developed and distributed in Yorkhill Division in 2005 to find out what the current level of understanding was amongst staff. It presents the findings from the questionnaire that indicate Yorkhill Chaplaincy Service works amongst a staff, who collectively have a good grasp of the religious and spiritual care provision. It shows how they were able to make the distinction in practice between what is meant by religious and spiritual in the terms set out in the Health Department Letter. The paper unpacks the implications of how staff felt to some extent that Spiritual Care was an area where they could make a contribution. This point is developed in conjunction with the findings that reveal some ambiguity about what criteria were being used to access the Chaplaincy service for spiritual need identified by staff. Another finding indicates how awareness raising and training have proven to be effective but the challenge still remains that there seemed little desire to be trained. The impact of this was evident in the varied commitment to inclusive measures for the diversity of population admitted by the hospital. The high response rate from this questionnaire has given depth to the findings enabling recommendations to be made to Spiritual Care Committees at Sector and Board level of the Greater Glasgow Health Board.

Keywords

Training, Awareness, Spiritual, Religious, Equality, Diversity

Main Article

Introduction

The Spiritual Care Committee at Yorkhill Division are responsible for implementing the requirements laid out in the Health Department Letter issued by the Scottish¹ Executive entitled *Spiritual Care in NHS Scotland*. A policy was written and an action plan drawn up. One of the objectives in the action plan is to provide training to staff about spiritual care. In 2005, a survey was developed and issued to staff in Yorkhill Division, Greater Glasgow Health Board. The site is a Women and Children's Hospital. The purpose of this survey was to find out the knowledge base of staff in order to develop a training module that would be relevant to the staff's level of training needs.

Methodology

The questions were drafted by Revd Alister Bull and developed by a working group. This was chaired by Revd Alister Bull (Head of Chaplaincy Services), Ephraim Borowski (Jewish representative), Marjorie Gillies (Senior Nurse) and Revd Hilda Smith (Chaplain). Yorkhill Spiritual Care Committee approved the questionnaire for distribution. Neil Sommerville, Clinical Effectiveness Assistant, prepared the formatting of the forms and compiling of the summary findings.

A percentage profile of occupation was gained of the 3000 staff and 655 survey forms were distributed to different professions and occupations. The overall response was 40.8% (Figure 1). This was considered to be a sufficient response to provide the representative data needed to reach the findings and make some proposals. The professions that had direct clinical contact with patients and families responded on the same level as the general return or above. The occupations with less direct contact with patients, such as technical staff, had a lower percentage rate of return.

Figure 1 – Occupational profile of responses

	NUMBER SENT	NUMBER OF RESPONSES	RESPONSE RATE (%)
GENERAL SERVICES	30	18	60.0
PATIENT SERVICES	7	6	85.7
ALLIED HEALTH PROFESSIONAL	51	34	66.7
MIDWIFE	85	39	45.9
NURSING	245	91	37.1
MEDICAL	90	33	36.7
OTHER	147	31	21.1
NO RESPONSE	–	15	–

There were 23 questions and the style of the survey used tick boxes for an easy response. Six questions focused on religious care, another six on spiritual care. Other questions focused on areas such as resources, accessibility, expectations and training.

Findings

Understanding

A key question included in the survey concerned the staff's understanding of religious and spiritual care. This was to test whether or not the terms used by the Health Department letter were understood and would therefore have an impact on the delivery

of care offered by staff to the patient. The staff were given the option of three statements and were asked what they would agree with most (Figure 2).

Figure 2

Spiritual care is exactly the same as religious care
Spiritual care is completely different from religious care
Spiritual care and religious care are different but can sometimes overlap

A significant proportion of staff (86%) identified that spiritual care and religious care are different but can sometimes overlap. A follow-through question was inserted to find out what was understood by this statement in practice, by asking staff to tick the top three statements that would best describe what religious and spiritual care would mean to them. The results are illustrated in Figure 3.

Figure 3

<p><i>Religious Care top three statements</i></p> <ul style="list-style-type: none"> – Religious ritual – Helping to cope with grief and bereavement – Providing support in difficult situations <p><i>Spiritual Care top three statements</i></p> <ul style="list-style-type: none"> – Providing support in difficult situations – Emotional Support – Anything that contributed to well-being

This reveals that amongst the majority of staff at Yorkhill, the terms referred to different areas of work, but on occasion overlapped.

Responsibility – Religious Care

The staff were asked about whose job it was to provide religious care. A significantly high proportion of staff (80.5%) identified the religious care role with chaplains. However, over 30% also indicated that it was the work of all staff. This is not to be misunderstood as

staff trying to do the Chaplain's work, but as a responsibility incumbent upon the staff to ensure that religious care needs are provided to families and patients. A follow-up question was therefore offered to elucidate if they felt this was indeed a part of their job, by asking what would best explain their answer. The main reason ticked was 'I feel the Chaplaincy Department can help me in my job'. However, nearly two-thirds of the staff felt it was not part of their job. Within the occupations only the midwives were in a majority when they felt they were to provide religious care. Nurses' opinion was split. Allied Health Professionals were very clear that it was not part of their job, with a similar but less strong response from the medical staff. This response would suggest that nurses and midwives who have a broad remit of care on the ward have a more inclusive approach to the responsibility of the care that they may feel they need to follow through. On the other hand, Allied Health Professionals seem to be more focused on their task.

For the majority that felt religious care was not part of their job, the main reason ticked was, 'It is the Chaplain's job' followed closely by 'I do not feel I have the personal religious resources needed'. This should not however be interpreted as staff disregarding a need, as another reason marked by many staff was, 'It is not part of my job but it is important to me'.

Responsibility – Spiritual Care

However, when the same question was asked about spiritual care the response within occupations was quite markedly different. The level of opinion amongst staff to provide spiritual care doubled compared to religious care. Allied Health Professionals were very clear that spiritual care was part of their job. The swing of opinion by the medical staff was the same but not as strong. The midwives and nurses also swung in this direction. The biggest reason ticked by staff was 'It was relevant to what I do' followed by, 'It is important to me'. While this responsibility did not rest so heavily on chaplains as religious care, the main reason to indicate why it was not part of some of the staff's job was that they 'did not feel they had the personal spiritual resources needed'.

Delivery of a Service at the point of identifiable need

The survey also investigated the specific way religious needs can be met, such as prayer, ritual, diet or bereavement. In all these needs except diet, 'calling a Chaplain', would be the staff's response to such need. In regards to diet, 'they would find out the nature of the patient's request'. The response was also high in contacting the patient/family's religious leader for prayer, rituals and bereavement. The Belief Systems and Cultures manual would be most likely used to find out about diet. Some staff, although a small minority, thought they could personally provide for the patient's religious needs for prayer, diet and bereavement. However, this was minimal when it came to a religious ritual.

Staff were asked, 'When do you think a Chaplain could make a contribution to the spiritual care of a family or patients, which no one else can provide?' (Figure 4).

Figure 4 – When do you think a Chaplain could make a contribution to the spiritual care of a family or patients, which no one else can provide?

	ALWAYS	SOMETIMES	NEVER	No RESPONSE
WHEN THE FAMILY/PATIENT ARRIVES ON THE WARD	6	171	40	50
WHEN THE FAMILY OR PATIENT ASKS FOR A CHAPLAIN	234	21	–	12
WHEN THE FAMILY/PATIENT HAS SETTLED ON THE WARD	17	187	11	52
WHEN THERE IS A CRISIS	79	158	2	28
WHEN YOU HEAR THE FAMILY IS RELIGIOUS	82	147	8	30
WHEN SOMEONE DIES	125	122	–	20
WHEN YOU THINK A PATIENT OR FAMILY NEEDS SUPPORT IN MAKING A DECISION	31	200	8	28
WHEN THERE ARE RELIGIOUS BELIEFS THAT AFFECT THE PATIENT'S TREATMENT	157	85	2	23

The figures do indicate one already recognized hospital procedure, that if a family or patient request is made for a Chaplain, contact is made. There were two other noticeable contributions that some staff felt the Chaplain could make in every circumstance.

First of all the Chaplain could be involved in helping out in the complications that may arise in treatment due to religious belief. This does raise a training issue, as this information is provided in the Belief Systems and Cultures Manual, and is available to all staff on the Intranet. However, it could be that a mediation role needs to be developed as well, to support families with religious needs, whether that be their religious leader or the Chaplain.

The other area was to provide support in bereavement. This aspect was identified as one of the main descriptions for the religious care of the patient or family. There should be some measure of caution in shaping a response mechanism for delivery of care because there were nearly as many people who would suggest a Chaplain only 'sometimes' meets this support. The staff did provide more responses to the ticked box description 'sometimes'. This was particularly at times, when the family/patient have been settled on the ward, when there is a crisis or when they think a patient or family needs support in making a decision. While families/patient arriving on the ward was at a similar level in this category, there was a small but significant response by some staff that a Chaplain would never make a contribution that no one else can provide at this point. However, a large percentage of staff responded by saying 'sometimes' in most situations listed in Figure 4 above.

The skill considered the most necessary by staff for a Chaplain was good people skills. This was followed by understanding a patient's religion and sensitivity to the fears and

stresses of a hospital stay. At the other end of the scale, only 30% of staff thought Chaplaincy should always be involved in mediation, although a considerable amount of staff felt it was an option in certain situations.

It does illustrate that in the views of other professions who are working in the clinical areas, they are making an assessment as to whether or not the support of a Chaplain would be appropriate in the circumstances they are dealing with. It would be valuable to discover through a focus group the criteria used by staff to make the decision to include or exclude the Chaplaincy department in the care of the patient and family. This is an area of support needed for staff who acknowledge that one of their felt needs for training was in relation to identifying spiritual need. However, a creative strategy would need to be developed as this did not translate into the same level of desire to be trained.

Awareness-raising of the service

The Chaplain seemed to be the biggest source of information for accessing the service, followed by information on posters. The Intranet, staff benefit booklet and leaflets had played only a small part in providing information. However, leaflets have only been distributed by the Chaplaincy team to patients and families and not to staff.

There were questions asked of staff about the facilities and resources provided by the Chaplaincy Department. The Rose Chapel and the Quiet Room, which are the current names for the facilities at the Chaplaincy Centre at Yorkhill, and the presence of on-site chaplains, were known by nearly everyone who responded. The Books of Remembrance that contain Certificates of Remembrance for babies, children or young people who have died at Yorkhill were also well known by the staff. They are kept at the Rose Chapel. The contact numbers for Chaplaincy and the on-call arrangements were also identified by two-thirds of the staff that responded. This knowledge level in these areas correlate to the level of training already indicated by staff when asked about training. This indicates that awareness training can make a difference.

Only half the staff that responded knew of the Intranet Chaplaincy site and the Belief System and Cultures Manual, with the least known resource being the Spiritual Care Policy. These resources are new by comparison to the well-established and well-known facilities in Chaplaincy. This would suggest that a promotion of these aspects is still needed if they are to be understood and used more effectively.

Equality and Diversity – Training

The staff were also asked about what their expectation would be for the Chaplaincy department to meet the religious and cultural needs of people from different faiths. The staff (75%) conveyed very clearly that the Chaplaincy department should use words and descriptions that show equality for any faith. It would be helpful to provide a focus group to investigate what words and descriptions would bring about that equality. About 80% of staff also felt it was essential that the Chaplaincy Centre which contains the Rose Chapel and Quiet Room should have religious items needed for people to worship from different faiths.

However, there was not the same level of certainty, around 60% of staff, for the Chaplaincy team to reflect the religious profile of Scotland, that information should be provided by the Chaplaincy to staff on religious and cultural needs or that the Chaplain should act as a facilitator to religious leaders in the community. It would be helpful to investigate why staff have different levels of opinion in the delivery of the service in these aspects of meeting religious and cultural needs. This would suggest that awareness training is the issue, as staff indicated they had not received training in these areas. At present, only new staff at Yorkhill are informed of these resources but are not taught how to use these resources.

The staff were also asked what training they would like to receive. While the desire for training was not proportionally great, two of the three highest requests by staff was for understanding cultural views on healthcare and using the Belief System and Cultures Manual. There is a dilemma that this survey has revealed, that while awareness levels are helped through training, the desire for training is very low and presents a significant challenge in the strategy to inform and equip staff, so that a service like Chaplaincy can be used effectively to make a hospital culturally sensitive.

Who is the service for? Families, patients and staff

A series of questions were asked about what was expected about Chaplaincy in regards to the team, the facilities and resources. Nearly 47% of those who had responded had used the Chaplaincy department to meet a patient or family's need and 50% had not used Chaplaincy. Also 10% indicated they had used Chaplaincy for personal reasons.

The staff were also asked if they would use the Chaplaincy Department for a family or a patient (Figure 5).

Figure 5

	NUMBER OF RESPONSES	PERCENTAGE (%)
YES	166	62.2
No	10	3.7
SOMETIMES	34	12.7
DON'T KNOW	44	16.5
NO RESPONSE	13	4.9

They were also asked 'Would you use the Chaplaincy Department for yourself?' (Figure 6).

Figure 6

	NUMBER OF RESPONSES	PERCENTAGE (%)
YES	60	22.5
No	86	32.2
SOMETIMES	35	13.1
DON'T KNOW	76	28.5
No RESPONSE	10	3.7

It would be beneficial to discover the reasons for either using the Chaplaincy department or not. What the figures immediately convey is that the Chaplaincy service is primarily viewed for family and patients before staff. However 7% of the staff responded to the opportunity to write comments at the end of the questionnaire, concerning the barriers to why staff did not use the Chaplaincy Department. The barrier raised the most, focused particularly on the overlapping role of chaplains, who meet both religious and spiritual need. This connection was felt by some to be incompatible with those who would appreciate spiritual support but did not have a religious connection.

How do these local findings compare with the national trends?

Quality Improvement Scotland produced a Report of the Scoping Study Group on the Provision of Spiritual Care in NHS Scotland. The occupational profile would suggest there is a difference between the two surveys as the QIS study asked, 'front-line, public facing staff members'. The questionnaire contained within the report had 9 questions. Some comparison can be made. There was a 33% return for the questionnaires. The findings that are presented indicated that staff considered that:

- access to spiritual care in the hospital setting was important (QIS - 98%) (Yorkhill - 77% of staff considered the spiritual care as important and relevant to the work they performed. This is slightly different from access)
- were aware how to contact a Chaplain (QIS - 74%) (Yorkhill - 73%)
- were aware of the provision of spiritual care (QIS - 64%) (Yorkhill - 90%)
- regarded spiritual care as everyone's responsibility (QIS - 70.9%) (Yorkhill - 62%)

The staff in this scoping study felt that 'reasons of emotional support and fear of death' were the most common situations requiring support from a Chaplain. This is consistent with the Yorkhill survey that also resulted in these themes.

Conclusions

This Questionnaire indicates that Yorkhill Chaplaincy service works amongst a staff who collectively have a good grasp of the religious and spiritual care provision needed for families, patients and staff. They were able to make the distinction in practice between what is meant by religious and spiritual in the terms set out in the Health Department Letter². Religious care was viewed by most staff to be the responsibility of the

²Scottish Executive, *Spiritual Care in NHS Scotland HDL (76) 2002*

Chaplaincy service, although midwifery staff did have a greater sense of sharing in this role. However, the staff did feel to some extent that spiritual care was an area where they could make a contribution. The results have raised some ambiguity about what criteria were being used to access the Chaplaincy service for spiritual need identified by staff. Awareness raising and training has proven to be effective but the challenge still remains that there seemed little desire to be trained in other areas of spiritual care. The impact of this was evident in the varied commitment to inclusive measures for the diversity of population admitted by the hospital.

Recommendations

1. To develop awareness training for:

- Spiritual care information available on the Intranet Chaplaincy site,
- The Belief System and Cultures Manual
- Implication of principles promoted in the Spiritual Care Policy.

The primary purpose of this awareness training is to equip staff with the principles of caring for all faiths and cultures and use the available resources more effectively to support this in their work practice.

2. To form a focus group(s) comprised of members of a multidisciplinary team to discuss:

- The criteria they would use to make the decision to proactively include the Chaplaincy Department in the care of the patient and family.
- Why staff have different levels of opinion in the delivery of the service in religious and cultural needs.
- Terminology that describes the Chaplaincy Service
- Assess the effectiveness of the Intranet usage by hospital staff
- Some of the new and less-known Chaplaincy resources, such as the Chaplaincy Intranet site need to be accessed more effectively.
- Have an agenda item for Yorkhill Family Bereavement Service. (This would enable the Spiritual Care committee to discuss through the implications of the strong association staff have given to chaplains and bereavement.)

3. Contact the Clinical Effectiveness team to develop ways of adopting case studies where spiritual care could have contributed to a better outcome.

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A PASTORAL RESPONSE TO PERINATAL LOSS

Revd Jane Parker is Assistant Chaplain at Leeds Teaching Hospitals NHS Trust

Abstract

An extended case study reflecting on a patient undergoing the process of a stillbirth, which has been expected prior to birth. The pastoral impact, role and response of the Chaplain is considered alongside theological reflection from a Christian perspective.

Main Article

Introduction

Perinatal loss includes both stillbirth and neonatal death. Stillbirth is the loss of an infant due to natural causes after the 24th week of pregnancy. Neonatal death is loss occurring within 28 days of birth (Carr, 2002, p.261). However, this definition does not take into account the impact on those involved.

Case Study

It should have been an exciting and wonder-filled time for Jenny, but it had turned into her worst nightmare. The baby she had carried for over 30 weeks was dying in the womb, and she had to wait until after the process of death to give birth. Life and death were inextricably bound together with a devastating outcome.

Jenny was a woman in her early twenties who came from a large family, and longed for children of her own. This was her third unsuccessful pregnancy; the first two babies miscarried at a much earlier stage. Reaching this point in her pregnancy, she felt that the nine-month journey was almost over and was looking forward to meeting her first child. She was devastated to find that her hopes and dreams had once again been shattered. Jenny's experience appears to bear out the comment of Hamilton that 'the more we extend the boundaries of technical possibility the more acute becomes the sadness, the anger, even the guilt people feel when something goes wrong' (1999, p.15).

From Jenny's perspective, once a problem was suspected, the interaction with staff appeared insensitive. She had been admitted on to a ward caring for women undergoing terminations, and also those receiving IVF treatment. Jenny had been placed in a side room, with the door closed. The staff appeared ill at ease with the situation, only entering the room to take her for scans to determine whether the baby had died.

Healthcare workers in the perinatal environment may experience emotional discomfort and stress on a daily basis. The Chaplain, as a colleague, can be a valuable resource at this point. Carson and Koeing state that healthcare providers 'may pull away from patients and insulate themselves against the pain that calls out to them from patients

and families' (2004, 27). Among other things the offer of Chaplaincy support may, in some instances, be a manifestation of this 'insulation'.

In speaking to the Chaplain, Jenny appeared resigned to her situation. She spoke at length about her hopes for the future, and about her fear that she would never successfully carry a baby full term. However, when referring to her presence on this particular ward, she became increasingly agitated. Although happy with the level of care offered by the nursing staff, she felt angry at being placed on a ward where some women were 'murdering their babies whilst others were trying to conceive'.

My own experience of losing a baby 18 years ago was brought sharply to mind. After being informed that my baby had died, I was placed on a ward with pregnant women, and experienced feelings of anger and confusion. In listening to Jenny, I became acutely aware that there is still the inappropriate practise of placing women who are pregnant or trying to conceive, with those losing their babies or facing a termination of pregnancy.

Pastoral Impact

It was a solitary place for Jenny. She appeared lonely and isolated, hidden away in a side room. Her partner, unable to cope with the loss of yet another baby, had returned to work. Kohner and Henley state that many couples 'are distressed to find that at the very time when they need each other most, they cannot be close to each other, and some find their grief actually pulls them apart' (1991, 83). Other members of the family had visited Jenny but, feeling inadequate, soon departed. Her bag remained unpacked – she was clearly not going to stay for longer than necessary.

Jenny had, in a few short hours, moved from the joy and anticipation of impending motherhood, to unfamiliar territory of loss and grief. But rather than wanting the baby to die quickly and so be relieved of her burden, she dreaded the moment when she would have to relinquish the child and face the future without someone to love and care for. The overwhelming grief that Jenny had begun to experience was not only for the loss of her child, it was also a painful recognition that her hopes for the future had been crushed.

As new life is created within the mother, much energy, time and emotion are expended. Jenny spoke of the all-consuming effect of pregnancy. Every moment appeared to have been taken up with thoughts surrounding her baby and their future together as a family. 'It is when the baby dies that the mother experiences events under which she has no control, and the father also feels he is unable to protect his partner or their child' (Simpson & Creehan, 1996, p.273).

There were also fears to contend with – fear of the birth, of going home empty handed, and of learning to cope alone with the death of her baby. Jenny acknowledged that lack of communication between herself and her partner was already causing difficulties in their relationship. Jenny's greatest fear at this time was the question whether she would ever be able to carry a baby full term.

Role of the Chaplain

In facing the death of her baby, the search for some form of meaning became relevant. Kirkwood recognizes 'The hospital is a place to hear questions and doubts about God that are unanswerable'. (1995, p.97). Jenny had many questions regarding the perceived injustice of her situation, which were impossible to answer. Carson and Koeing surmise that in asking questions the individual is 'attempting to define the relationship of their lives to ultimate truth and reality' (2004, p.74).

As the Chaplain involved in this particular scenario and feeling inadequate and knowing, I didn't have the means to take away the anguish; my role appeared to represent the loving presence of God even in a place of great distress. By drawing alongside Jenny in her pain, it was possible to hear her unique and personal story, and to allow her to explore the beliefs brought into question by her experience. Only from these, and in her own time, might hope emerge.

Anderson and Foley comment 'We tell stories of a life in order to establish meaning and to integrate our remembered past with what we perceive to be happening in the present and what we anticipate for the future'. They conclude 'Story telling, for the sake of making a memory, is not only the central work of grieving; it is the way each of us closes the story of a life' (1998, p.99). Receiving her story delivered a powerful message that I valued all the aspects of her life, including her wholeness and her brokenness.

Jenny attended church as a child, and hoped, for the sake of the baby she carried, that God was 'alive and well!' She appeared uncertain about the nature of God, yet wanted to take comfort from the notion of a loving God. In offering support and comfort, I hoped to convey – in however limited a sense – that, through Christ, God reaches out with comfort and healing. It was not her strength of faith that was all-important (and consequently another locus for failure and despair), but God's love and grace which are unconditional and unlimited.

Response of the Chaplain

The pastoral response offered by a Christian Chaplain is grounded in the tradition of care and compassion; this is reinforced by biblical values and gospel stories. Early psalms are filled with the anguish of those who felt that God had forgotten or turned away from them and yet many later psalms encourage the recognition of God at all times and in all situations. They reflect the experience of humanity in times of personal distress and also in times of great joy. God is present to help even though the world may appear at times austere and frightening.

The Gospels are filled with stories of care and compassion. Kirkwood comments: 'If a theology of Christian pastoral care is to have any real validity, it must find its roots in the person and work of Jesus Christ' (1995, p.117). Christ himself showed compassion and empathy in all his dealings with needy and hurting people. He was filled with compassion for those who were like a sheep without a shepherd, and was sensitive to their needs, looking deep into their hearts. The love of Christ provides the base on which to build sensitive pastoral care. Throughout the gospels, we are encouraged to love God and love

our neighbour. In summarizing pastoral care, Kirkwood encourages the Chaplain to have confidence in a God who is relevant, compassionate, compelling, suffering, patient and encouraging (1995, p.133). The emphasis on love, despite the institutional failings present within Church history, should be the foundation of all Christian ministry.

Yet the question still remained with Jenny, 'why did God allow this to happen?' If the goodness and power of God is unlimited, then how can it be reconciled with suffering and the presence of evil in the world? Suffering that is not caused by human evil is difficult to reconcile with belief in a God of love. Although the bible does not offer any final solution to this dilemma, there is the understanding that through Jesus, God shared the experience of human suffering. Fiddes' understanding is 'of a God who suffers eminently and yet is still God, and a God who suffers universally and yet is still present uniquely and decisively in the sufferings of Christ'. (1988, p.3). McGrath comments that many Christians 'have found that God's grace and love are experienced most profoundly in situations of distress or suffering'. (1994, p.264)

Nouwen used the image of the wounded healer to express a clearer understanding of the role of carer. He maintained that, 'the minister is called to recognize the sufferings of his time in his own heart and make that recognition the starting point of his service'. The care offered 'will not be perceived as authentic unless it comes from the heart wounded by the suffering about which he speaks'. (1994, p.xvi).

The Child Bereavement Trust recognize that death is often a taboo subject, but states that it is 'by acknowledging the loss and finding ways of accepting the reality that helps the bereaved to express their painful feelings and allows them to grieve for the person who has died'. Research and experience has shown that, following bereavement, women need memories yet men want restoration to normality. This was Jenny's experience. She felt that her partner's desire for normality in his life was his attempt to forget the pregnancy and baby.

In the New Dictionary of Pastoral Studies we are reminded that mourning is usually retrospective, in that it looks back over the life of the deceased. However, the loss of a baby is more about relinquishing hopes and wishes for the future (Carr *et al*, 2002, p.261). With minimal evidence of the baby, there may be difficulty in coming to terms with the loss. To help Jenny actualize the loss and provide her with memories, she would need tangible mementos.

For a stillborn child there is a legal requirement for the birth to be registered within 42 days and a certificate issued. The body must then be buried or cremated. Jenny enquired about the possibility of prayer for her baby following the birth. A service of blessing in the hospital and funeral at a later date appeared to meet her needs. Kohner and Henley comment that holding some form of service 'gives the parents an opportunity to express their grief and also their love for their baby. It can be a way of acknowledging the importance of the baby, and can create memories to hold onto in the future' (1991, p.75). Anderson and Foley examine the experiences of those who have suffered perinatal loss, and found that ritual was the first step towards resolving grief. They speak of 'crafting a

ritual' that allows the story of the family to bond and heal. There is little appropriate liturgy for this situation, but existing forms of service could be adapted or new liturgy formed to meet the needs of the family. The aim would be to bring peace in the knowledge that the baby is safe with God, whilst providing memories and healing the grief. Anderson and Foley conclude; 'In the face of still birth they need to do something to counter their feelings of powerlessness and grief'. The ritual could be devised 'that helps parents to affirm their relationship to their dead child, to connect the child's short lived story with the divine narrative, and to enable the process of separation and grieving to begin' (1998, p.133).

Jenny was interested in compiling a service with appropriate readings, reflections, scripture and prayers. She was relieved to talk about issues her partner was unable to face, and recognized that she walked a lonely road. The Stillbirth and Neonatal Death Society (SANDS) has pioneered pastoral care for pregnancy loss and the death of a baby, and in their guidelines offer ten principles for good practise (1991, p.10). It is noted that the quality of care received by parents can affect their ability to grieve, and SANDS encourage those who care for the bereaved to take the opportunity for training and development of understanding and skills.

Despite having little available liturgy and no commonly recognized rite for acknowledging loss in pregnancy, it is important to affirm the child's uniqueness before God and the recognition that death of this nature is a real loss. Sheila Cassidy believes that the carer's attitude towards and understanding of suffering, dying and death is crucial. She encourages carers to keep in their view the cross with the resurrection, the dark times with joy, in other words a 'paschal overview' (1988, p.65).

Conclusion

The role of Chaplain as outlined in *Spirituality and the Practice of Healthcare* is threefold. As a pastor, the Chaplain offers pastoral and spiritual care, and as a priest they provide and co-ordinate religious services. The final role is that of prophet, where the Chaplain acts as advocate, speaking out on matters of justice (Robinson *et al*, 2003, p.240). Healthcare is perpetually changing through the Government's programme of modernization, and currently many trusts are running enormous deficits and staff are facing the possibility of job cuts. Wards are closing and funding is not readily available for new ventures. Despite these difficulties, it is important to draw attention to issues that affect the well-being and overall care of the patient, and to encourage and facilitate change where appropriate. In the case of Jenny, it would be to review the policy on the appropriate ward to place patients with particular needs. Being placed on an alternative ward would not have changed the outcome, but would have made a positive difference to Jenny's experience in hospital.

Although some may insist that pastoral care and politics are diametrically opposed, Pattison argues convincingly that if pastoral care 'is truly to alleviate sin and sorrow and to nurture human growth, it must widen its concern and vision beyond the suffering individual' (1988, p.88). He raises issues on inequality and injustice that create and

extend human suffering and challenges these by looking at the policies and insights of Latin American Liberation Theology. He strongly promotes socially and politically aware pastoral care, which is central to developing human potential. Traditionally, pastoral care has concentrated in looking after individuals, but Pattison suggests that social and political issues, which can be avoided if appropriate action is taken, often cause suffering.

Caring for the Spirit (2003), the development strategy for Chaplaincy and spiritual healthcare workforce, states that the challenges and opportunities of a changing world, as well as the weaknesses in the current system, highlight the need for a new strategy for chaplains. One such strategy suggested is proactive care for patients.

Human suffering and death remains a mystery and a reality. Amidst the overwhelming emotional impact, the Chaplain is the transforming presence, and a concrete sign of the presence and ultimate love of God. From the Christian point of view, the doctrine of incarnation is the basis for the creative theology of suffering. God suffers both universally and yet is still present in the Cross. Openness to God's suffering presence in his or her own suffering, enables the Chaplain to be a channel of divine healing.

From the example of Jesus we are called to see the ministry of care through to completion, yet the role of the healthcare Chaplain often makes this task impossible. Gordon reflects on the carer being the one to hold the hand of the cared for, effectively promising to hold with their love those who are struggling, distracted, weak or vulnerable. The parallel is then drawn with the love of God, which never lets go (2001, p.21). In the case of Jenny, our meeting was limited and she would soon be leaving the hospital. On reflection, was the pastoral response adequate, and was there any further care that could have been offered? Resources were offered to help her throughout the grieving process and look forward with hope. She was encouraged to find support outside the hospital in the days ahead from her local church, as well as agencies such as such as the Stillbirth and Neonatal Death Society and the local Miscarriage Association. Jenny was also aware of the bereavement counselling service that could be offered through the hospital, and the annual service of remembering for those who have suffered baby loss.

Postscript

Jenny's son was born two days after our meeting. The on-call Chaplain conducted a simple service of blessing, and two weeks later a minister conducted the funeral service in her local church. Jenny returned to the hospital for a series of counselling sessions with the bereavement support midwife and continues to wrestle with the meaning of her experience.

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THE FAR COUNTRY: JOTTINGS ON SIX YEARS AS A CHAPLAIN AT RAMPTON HIGH SECURE HOSPITAL

Revd Bob Whorton is the former Chaplain at Rampton High Secure Hospital

Introduction

The three High Secure Hospitals serving England and Wales are Broadmoor in Berkshire, Rampton in Nottinghamshire and Ashworth in Merseyside. They exist to keep the public safe, and to provide a high quality service for mentally disordered offenders. Those who are admitted are judged to be 'an immediate and grave danger' either to themselves or to others. Many have committed the most serious of offences, but the Hospitals are not prisons - the staff are nurses and not prison warders. I believe that a society may be judged on how it deals with its most vulnerable and despised members. It is to the credit of our society that we choose not to execute our mentally disordered offenders – instead we offer them care and treatment.

A brief Recent History

In the last 25 years, there has been radical change in all three Hospitals. Perhaps the beginning of this change can be traced back to 22 May 1979. On the evening of that day Yorkshire Television screened a documentary called *The Secret Hospital*, which portrayed the alleged mistreatment of patients in Rampton. This earned the director, John Willis, an International Emmy and the hospital a government enquiry (the Boynton Report was published the following year). There are only a few patients here now who remember those days. They speak of the choice on a Sunday morning between going to church and scrubbing the floors. Church attendance was impressive in those days.

In 1999 came the Fallon Enquiry and its report into the Personality Disorder Unit at Ashworth, where certain serious security issues had come to light. The police at the time were investigating allegations that a child visitor had been abused on one of the wards. The Report recommended the closure of the hospital.

At this time there was great uncertainty in all three hospitals. The Government was concerned about accountability to the NHS, professional and geographical isolation and the sheer size of the hospitals. There were voices calling for the closure of all three hospitals and the creation of several small high secure units dotted around the country. But who would want a miniature Rampton on their doorstep?

The Government's response was to keep the three hospitals, but to increase security and to bolt them firmly into the NHS. Sir Richard Tilt, former Director-General of the Prison Service, was asked to review security. On April Fool's day 2001, the West London Mental Health Trust was formed, incorporating Broadmoor, and Nottinghamshire Healthcare Trust was formed taking in Rampton. Mersey Care NHS Trust was formed in the same year and later Ashworth was absorbed into it. The hope was that work in the hospitals would be much more transparent; the large Trusts would be well funded and

able to attract the best professionals; and the patients within the new Trusts would be able to move easily between low secure, medium secure and high secure units.

The work of a Chaplain in a high secure hospital

After working my apprenticeship at Broadmoor, I arrived at Rampton in 2000. I am now making a sideways move into hospice Chaplaincy. In many ways the work at Rampton is the same as any other healthcare Chaplaincy work. We listen to people's stories, respond, reflect, pray, offer worship, create rituals for anniversaries, facilitate groups and try to ensure that there is adequate provision for people of faith and for people of no faith. We share laughter and tears.

I think our key work is with hope. In the film *Clockwise* the character played by John Cleese is contemplating the ruins of his life. He lies at the side of a country road dressed in a monk's habit and says: 'Despair ... I can live with the despair. It's the hope I can't cope with'. Our work is holding onto the hope for someone until they can hold it for themselves. I like to picture it as a return from the far country, from the place of exile. 'You, who used to be far away, have been brought near ...' (Ephesians 2.13).

A sentence by Ladislaus Boros (written in the days before inclusive language was commonplace) has struck me as peculiarly appropriate to our work here. 'The worst degradation of man takes place if he is unmasked or 'shown up' ... If someone in the goodness of his heart, without passing judgement, approaches us reverently, we feel "clothed" and protected by his goodwill' (1979, p.65). For those who have been labelled as monsters, who are unmasked or unmade, our task is to offer clothing.

Like all chaplains we work with reframing. The best set of frames I know is the one that starts off with 'I am shit', progresses to, 'I am in the shit', and finishes with, 'I will bag up the shit and sell it as compost'.

There are differences because the environment is special. Our bags are X-rayed each day and we may have a pat-down search as we come in to work or leave work. Breakaway training is mandatory – techniques for safely breaking free from an attacker without injuring them. We carry keys and have to remember to lock doors behind us. When we walk down the corridor we have to remember not to pick our nose as it could be picked up on camera. And we have the opportunity to get to know people over a long period of time; I have been working with some patients for five years. The subject material we deal with may be different to other Chaplaincy contexts. It is a strange thing, but you get used to hearing about abuse, extreme violence and the disintegration of the personality.

I have discovered that I am very similar to the people inside the hospital. We have the same potential for goodness and for evil – except I don't have the level of trauma they have, and I wasn't abused in my formative years. I still struggle to know what is this thing we call mental illness. And what is the condition we describe as personality disorder? I have to resort to metaphors. Perhaps it is a spirituality which is back to front, or the source of one's being contaminated at source – poison in the spring. Or a container which can no longer contain? Our patients often describe a dark aloneness which is the opposite of community.

Change

What are the changes I have seen at Rampton over the last six years?

- An accelerated programme of discharge from Rampton into medium secure units. Some patients were kept here inappropriately because there were not enough medium secure beds. Patient numbers are falling.
- More security measures in place (e.g. a new double fence and new reception building). Patients subject to more controls.
- Difficulties of communication around a huge Trust.
- The creation of a Dangerous and Severe Personality Disorder unit (DSPD).
- The total segregation of male and female patients in line with the DoH report on women's mental health 'Into the Mainstream'.
- More patients coming from prison with mental health issues.
- Upheaval for patients as they move wards – in preparation for new building schemes. The hospital is becoming more and more specialized. In the future Rampton will be a collection of communities catering for those with mental illness, personality disorder, DSPD, Learning Disability, deaf patients and women patients.

How has Chaplaincy changed?

- Our staffing levels have increased from 1.7 WTE chaplains to 3.5 WTE chaplains.
- Our worship centre has been redesigned so that there is now a Christian chapel and a Multi-faith Room.
- Greater variety of faith groups involved in the hospital.
- Gradual acceptance of Chaplaincy by the organization – greater involvement with the Multi-Disciplinary Teams.
- More specializing (e.g. appointing lead chaplains for DSPD unit and for women patients).
- Rising to the challenge of meeting the religious needs of three groups of patients who are not permitted to meet each other – men, women, and patients on the DSPD unit.
- New security measures have meant finding new ways of doing things (e.g. our volunteers can no longer bring in home-made food, so everything has to be purchased in-house).

As I leave Rampton I go with much sadness, and I take a rich experience with me. A little bit of the hospital is in my blood.

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RITUALS AND RECOVERY: THE 'SACRED SPACE' OF THE SMOKING ROOM IN A MENTAL HEALTH ACUTE UNIT

Revd Christopher Newell is Community Mental Health Chaplain for Cornwall Partnership Trust

Introduction

I have recently spent some time as a patient in an acute mental health unit. When I am well I work as a mental health Chaplain both in the community and in acute units, so I have had the opportunity over a number of years of exploring the uncertain boundaries between psychosis and spirituality, madness and sanity, the sacred and the profane. One of the most fascinating areas of this personal exploration is how important the experience of private and communal rituals are in the ways that we confront and manage our mental health and how we re-integrate them into our sense of personal self and common humanity.

The rituals of being human

We can easily make the mistake of relegating the idea of ritual behaviour purely to the religious realm. The very activity of being human and engaging both individually and corporately in myriad human activities involves the actions of unique rituals, a way of doing things, of establishing patterns and rhythms special to that particular activity, that particular social group. There are rituals in family relationships, in the way we engage in sport and cultural activities, even in the way we shop. Just look at a supermarket car park on a Sunday morning and the social ritual of the weekly family shop has largely, for many, replaced the sacramental ritual of church attendance. By this observation I am not in any way seeking to devalue the religious significance of rituals. The experience of receiving holy communion whilst I was in hospital was one of the most deeply moving encounters with a religious act which offered, for me, a way of communicating with transcendent truths at a time when I was finding hard to be in touch with myself.

We can also make the mistake of seeing social rituals as having largely replaced the idea of the sacred. The sacred remains implicit in activities beyond the narrow definition of the religious, of an act of reflection and communion that makes sense of who we are in relationship to the world around us, to the people we love, to those deeper, transcendent truths I mentioned earlier. This is the area I wish to briefly explore in relationship to the 'sacredness' of the smoking room and how, in the laudable interests of health, we might be in danger of losing something rather special and irreplaceable.

Consider the act of rolling a cigarette. What do you need? A comfortable place to sit, a place to put the paraphernalia of the rolling process: baccy itself, ciggy papers, filters (an optional extra) and the lighter (if you are allowed one). The other important ingredient, particularly if your hands are unsteady through anxiety or the effects of medication, is a

helping hand, a friend to participate in the ritual. Indeed, if you have not been able to leave the ward, the gift of some baccy from another may be needed. So here are the elements of a ritualistic process, which has within it its own regular determined pattern, its own symbolism and imagery, its own need sometimes to take place at particular times.

How often, after what has felt like a gruelling ward round or particular times of stress and anxiety, has the overwhelming desire to enter the 'sacred' room and perform the 'sacred' act and, in the process, share in contemplation with yourself or with others, your own thoughts and reflections? How often, when sleep has been hard to find at 3am do we find fellow travellers in that smoking room and share cups of tea and the rolling of a fag and, in that sharing, rediscover a little of ourselves? At times like these, there is no other place to be and nothing more important to do. It feels like, it looks like, it is an act of the deepest communion. Burnt cigarette marks on the carpet and stray strands of tobacco and scattered cigarette paper packets reveal the purpose of this 'sacred space' as profoundly as icons and candles do a chapel. The ritual of the act of rolling a ciggy can, in itself, like the most sacramental of religious rituals, be deeply nurturing, an act of profound significance and meaning. It can, for a few contemplative seconds, seek to make sense, both personally and communally, of a human life lived for a time in the context of an acute mental health unit, a context which, often, finds it hard to provide such moments of reflection, meditation and contemplation. This can be particularly true of psychiatric intensive care and forensic units. It can do what all ritual practices help us do – provide a deep, transcendent sense of our personal and communal humanity, a humanity which is sometimes hard to discover in ourselves and others when we find ourselves in profound emotional and mental crisis.

The smoking room, however, for the best of health reasons, is a doomed space in our mental health hospitals as it has become in our general hospitals. The unit at which recently I was a patient provided the smallest of 'pods' at the end of each bay, barely large enough for two people to sit. The only other alternative was to brave the freezing weather and smoke outside in the garden, reducing the act of smoking to its barest essentials. I say all this as a committed former smoker who finds himself approving the soon to be enforced ban on smoking in public places. At the same time, I am deeply worried about the implications for those who find themselves needing to stay in a mental health unit, where, it is said, over 70% of patients may be smokers. Even, as is likely, acute mental health units will be deemed 'residential' units and so smoking will continue to be allowed, the smoking 'space' will not be seen as a priority in terms of space allotted to 'therapeutic' activity. And as I have tried to explain, it is the nurturing, self-motivated, reflective ritual of a particular practice of smoking, the process of rolling your own, or rolling someone else's own, which we are in danger of losing, and I am not sure any other physical human act could replace it.

So I make perhaps a forlorn plea for those concerned with the holistic care of people in our mental health units, concerned with their spirituality and humanity, not to dismiss the value of the smoking space, a value often unseen and unregarded, but profoundly 'sacred' in the strangest, mysterious but most human of ways.

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CONTRIBUTION TO A CHAPLAINCY STUDY DAY

David Hamilton is a Clinical Nurse Specialist (palliative care) at Guys and St Thomas' NHS Foundation Trust.

Context

This talk formed part of a session on encountering illness on a study day for chaplains and volunteers organized by Revd Rosemary Shaw.

I've been asked to talk briefly about my role as a clinical nurse specialist in the palliative care team and how my work impinges on my own faith. I have to confess that the concept of speaking about faith and spirituality to a bunch of chaplains does fill me with a certain amount of trepidation, however, here goes.

I guess a good starting point is for us all to be clear about what we mean by palliative care and what my role as a clinical nurse specialist is. Palliative care is the care of patient with incurable disease. The aim is to alleviate symptoms of illness; these symptoms might be physical, such as pain, vomiting; or they might be psychological – depression, anxiety or, indeed, as you know too well, spiritual – where is God? What have I done to deserve this? We also aim to address social symptoms of the disease – who will look after my children when I die? The intention is to maximize life quality for patient and those who care for them; we know that terminal illness affects more than just the patient. If I can provide a supportive environment for those around the patient, often the patient in turn feels more supported.

As a nurse specialist, I regularly assess patients who are referred to our team within the hospital, monitoring and improving their symptoms and referring to other agencies as required, (e.g. local hospices and community support teams). Frequently, my colleagues and I will help facilitate appropriate end of life care, being directly involved in about 3 to 8 deaths per week. We also aim to provide ongoing bereavement support for family and friends of patients who have died under the care of our team. All this is achieved through our multidisciplinary working model – we are a team of nurses, doctors, psychotherapist, with strong complementary therapy, and, of course, Chaplaincy links. The majority of the patients that I see are cancer patients; however, colleagues and I also see anybody with a life-limiting illness, (e.g. cardiac disease, renal failure and patient with AIDS-defining illnesses).

So that's the easy bit. What about my faith and how does my work impinge on it?

My own faith journey is rooted in the Christian tradition. Early days of exploring my own sense of spirituality led me to a charismatic, evangelical model of Christianity, full of certainties and little room for doubt. Like many of us, I seem to continue on an evolutionary process of faith. I guess I don't like spiritual labels too much, but if I had to be defined now in Christian religious terminology I would probably be thought of as a

liberal. My sense of spirituality is very real for me, I think I have a strong sense of the sacred and my faith very much determines both who I am and how I try to interact with the world. Incarnate theology, God with us and in us, allows me to root my faith in the reality of the now, as well as the possibility of future revelation. I can usually be found in church on Sunday morning but often don't feel like I meet God until I garden in the afternoon.

So now for the tricky bit – does my work impinge on my faith and vice versa? Let me share a couple of thoughts. Palliative care historically has been influenced by religion; particularly I am conscious of both Buddhism and Christianity and their involvement in hospice and palliative care faith initiatives. On the whole, the shaping of the modern palliative care movement by faith groups has been positive. However, on a personal level I am cautious that the theological meaning I may or may not find in death and dying is not what my patients and their carers necessarily need. I bring to work my own spiritual identity, and this includes all my spiritual hurt, confusion and baggage. I need to be aware of this and the potential damage I could do. It is not my role to directly or indirectly share my faith in the assumption that it will work for others. Rather I try to give space for those I care for to explore for themselves the meaning of their dying, if they can find any meaning. This is more difficult than it sounds because it requires me to be able to distance myself from my experience of encounters with people who are ill, so that I can have a degree of objectivity in my relating. To put it another way, we need to be able to think critically about what we do, think and feel because our own agendas can very easily come to be played out in our encounters with others. This of course requires dedicated time to reflect – often a luxury I do not have with a very hefty case load.

At the start of this talk I described part of my role being to alleviate symptoms of terminal illness. I think I do this reasonably well. What I and other palliative care clinicians do less well is to alleviate suffering. It's easy to control many physical symptoms like pain, but what about the progressive loss of identity due to increasing dependence, what about weight loss or faecal incontinence? What about the inability to hold your children, share with your lover, dream about the future, what about the pain of saying goodbye when the time does not feel right? Suffering, I guess, is the big challenge for me from both a work and faith perspective.

One eminent palliative care doctor suggests that 'a doctor who leaves a patient to suffer intolerably is morally more reprehensible than the doctor who carries out euthanasia'. The subject of suffering and theology is of course not new. But what I have to do in my daily work of being alongside the raw suffering of dying is to find a tangible way of creating some sense of meaning. But what do you say to people who come to hospital to get better? This is what they want, but this is not what I have to offer. The need for me personally to find some sense of meaning in such suffering is important. Painkillers, antidepressants, psychotherapy, complementary therapy and indeed Chaplaincy (with the greatest respect) are not enough to resolve some patients' suffering. And so I daily observe the suffering of my patient and their carers.

Does my Christian faith help?

In finding the meaning, yes, I think it does, but it also raises more questions. For a time, the Christian concept of God suffering on earth was useful: God knows what it's like, he's been there. But I am not sure this is enough. Does another's suffering, even God's, make any difference to another individual's pain? Perhaps it may for some, but for many it may not. For my personal need to make sense of this suffering, knowing that God suffered is not enough. Perhaps there is a sense of reassurance that the Christ story reflects our own experience and therefore allows us to relate to this idea of divinity. Just like our own suffering shaping our stories, so maybe for me God's life is now shaped by the story of Christ. This helps but it also doesn't feel like it is enough. None of this is ever resolved or tidy, but my own faith and belief gives me another language to think about my professional experience.

For me, trying to make any sense of the suffering I work with leads me to the core understanding I have about God, a concept of a loving God. Where can I see this loving God in the midst of the mess of death and dying at St Thomas' hospital?

Well, one thing which makes a difference to me is a fairly familiar scenario. I am often humbled by the presentation of love as patient and carer suffer: the husband who never leaves the bed side; the child who gently cleans and moistens the lips of his dying father; the bereaved friends embracing each other. Suffering, it would seem, invokes beautiful manifestations of love-in-action. This is real love because it moves beyond fear and it embraces the unknown and faces the profoundest difficulties human beings are likely to encounter. It certainly is tender but it is tough too! Perhaps in these very simple yet life transforming and enhancing actions I see my loving God. Suffering transformed by love. People imitating God. God reflected in human form. Or perhaps I simply see the best of humanity. Whatever it is, it enables me to work another day.

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BREAKING BAD NEWS DURING PREGNANCY AND EARLY LIFE

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Context

This article presents the key messages from a study day hosted by the University of Derby. During the day we explored the complex issues of delivering bad news in the field of medical ultrasound and screening. As this article emphasizes, the complexity exists for many reasons. Firstly, there is the diversity of experiences, either in relation to the individual responses to being pregnant and certainly the individual responses to bad news (from both the messenger and the recipient). In addition, there are issues in the technological advances which can detect complications during early pregnancy, such as 3-D images, which impact on the way in which bad news is delivered. The study day was very interprofessional, with participants from different disciplines contributing to a diverse knowledge-base, and therefore there was an emphasis on the practical skills necessary to work together as teams to buffer the potential impact of these stresses. The article reflects ideas from a sonographer and a hospital Chaplain and highlights the potential benefits of support given and received within an integrated team.

Main Article

The Sonographer's Story: The Context of Medical Ultrasound and Screening

Rosie Simpson, Department of Radiography, City University, London

Healthcare staff are unlikely to enter their professions because they wish to upset their patients, though this is an integral part of many healthcare roles. Being given bad news is inevitably upsetting for the expectant mother; while the sonographer, on discovering an abnormality, is in a situation that they find professionally satisfying – since they have found the abnormality – but personally distressing (Simpson and Bor, 2001).

Antenatal ultrasound scans are a routine part of expectant mothers' care though both good and harm may result from this procedure. Normal findings can never guarantee a healthy baby. Abnormal findings may be untreatable or they may have uncertain implications. Expectant mothers may attend without a clear understanding of the possible outcomes; they may come alone, with partners or other adults, or their children, while some have a limited understanding of English.

The sonographer will generally start with some explanation and friendly interaction with the expectant mother. While scanning, they may point out various features of the foetus but then notice that something looks wrong. They will need to scrutinize their images to be certain of their findings. The sonographer will find it inappropriate to continue to describe what they can see as they scan and their interaction with the expectant mother will no longer be relaxed and open. The expectant mother, who may be in a hyper-vigilant

state will realize that something is wrong, as the sonographer cannot avoid communicating this, even via inadvertent non-verbal communication. Ultimately, one cannot not communicate (Watzlawick *et al*, 1967). The image is in real-time and if bad news has to be given there is no time or opportunity to prepare for this.

When an abnormality is discovered, the sonographer has to think about how to deliver the bad news while still scanning to obtain as much clinical information as possible, fearing that if they say they are concerned they could initially be mistaken and also that the expectant mother may not want them to continue scanning. They may then unleash a reaction with which they cannot cope. They may be unable to answer all the questions, and it is a universal law that only the most senior and respected doctors earn applause for confessing ignorance (Buckman 1984). They may hide behind professionalism and objectivity, ultimately becoming detached from their own feelings (*ibid.*). This both discourages colleagues from offering support and prevents the ability to reach out to frightened patients. Staff then become part of a problem rather than a resource. They then are likely to have to carry on with scanning the next expectant mother.

Psychological discomfort commences for the sonographer when they realize there is a problem and they anticipate giving bad news (Simpson & Bor 2001). This distress centres on an awareness of the impact of the bad news combined with lack of confidence in their skills in delivering it. Sonographers may take responsibility for expectant mothers' reactions, assuming their competence in giving bad news dictates this. Other factors making the situation worse relate to not having privacy when imparting bad news, the expectant father having a different reaction from the mother and difficulty finding the doctor that the expectant mother needs to see (*ibid.*).

If the sonographer lacks confidence in their skill at communicating bad news, or dealing with the aftermath, due to lack of training or previous difficult experiences, this will add to distress for both. Professionals giving bad news should both recognize and receive recognition that they are doing a difficult job, both personally and professionally. Need for support should not be seen as a weakness.

What is Bad News?

Some information may be universally interpreted as bad news. However, in some situations there will not be consensus on the meaning. For example, the news that a pregnant woman is carrying twins, or a girl, may be interpreted neutrally by a sonographer and may delight one patient and devastate another.

It follows that situations must occur where the bad news deliverer and recipient will not attach congruent meanings to the news. The sonographer could be perceived as insensitive if imparting information without awareness of its impact on the recipient.

Findings that are not Medically Relevant

Findings described as 'soft markers' are minor defects that, in isolation, are not believed to be significant. In some hospitals, protocols dictate that an expectant mother should not be told if an isolated soft marker is found, on the basis that this would cause them to

worry needlessly and may spoil their experience of pregnancy. In other hospitals, mothers are viewed as having a right to this information regardless of its significance. The sonographer will therefore have to either withhold information due to a paternalistic imperative, or to possibly generate anxiety trying to explain the meaning of a defect that is not, as far as we know, significant.

The Hospital Chaplain's Story: Picking up the Pieces

Pip Short, Chaplain, Derby Hospitals NHS Foundation Trust

Although chaplains are not usually the ones to break bad news, they are often called in to give support afterwards. After foetal loss, this involves working with the staff, talking with the family and offering practical help.

Just as the reaction to bad news is very individual, so is the way in which people handle the next few hours and days. In most cases there is a strong drive to do something, and discussion about the funeral or remembrance service or the possibility of naming and blessing the baby can give parents and other family members a focus in their confusion. It also helps them to realize that their child is being recognized and valued by others outside the immediate family.

This can be particularly helpful for the father of the baby. Often the attention of everyone is directed mainly towards the mother and, because most fathers try hard to be 'strong' for the mother, their own feelings and needs may remain unrecognized. They may be quite unprepared for the extent of their emotional reaction and find it difficult to discuss this with anyone, unless they are given specific encouragement to do so.

Similarly, the grandparents have a double suffering. They are sad for their own child's pain and grieving for their lost grandchild. For grandmothers it may be a stark reminder of foetal losses they suffered many years ago, when there was no opportunity to see and handle the baby or have a funeral. They are sometimes helped by the offer of a remembrance service for their own lost children. It is never too late.

For families of faiths other than Christian, there may be a difference in attitude between the more traditional older generation and the parents of the child who has been born and brought up in the United Kingdom. Often it is the Chaplain who helps them to find some common ground, can liaise with the Muslim faith leaders and may be asked to take part in the funeral. Sikh families are especially pleased if the Chaplain will share the service with a Sikh priest.

There are other issues which may add to the stress of the situation. Decisions have to be made about burial or cremation; there are the confused emotions when one twin lives and the other dies. Going home brings the challenges of looking after other children, meeting friends and neighbours, seeing people with babies and the crowd of mothers at the school gate. There may be several weeks to wait for the funeral, especially if there is to be a post-mortem. There may be memories of previous losses or fears about more in the future. The parents' own individual reactions and emotions may put a huge strain on their relationship.

Most people want and need to tell their story and to have someone, who is not personally involved, to be there to listen and to help them make some sense of what has happened. This requires a caring, listening ear, unquestioning acceptance of what is said and assurance of confidentiality.

It is surprising and humbling that people in distress are usually so ready to talk openly and honestly. It is essential to try to build rapport as gently, but as quickly as possible. This will be more successful if the person offering support can be very still, with body language which indicates that their attention is fully on the person in need. Some questions are useful, but much more can be achieved by non-verbal responses and allowing periods of silence. It is helpful to summarize what has been said, then gradually to discuss first steps in moving forward and how they might be achieved.

There is no blueprint for helping people to cope in situations of foetal loss or any other death. It is important, however, to be honest and to allow those who have suffered the loss to take time to absorb what has happened. Discussing what can be done practically to recognize the loss of the baby often helps parents to feel that they have been able to do something for their child despite what has happened. That is empowering and gives strength.

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CASE STUDY OF 'CLAIRE'

Revd Lissa Gibbons is Team Chaplain at the Buckinghamshire Hospitals NHS Trust

Context

At staff meetings we take it in turns to present a case study, encouraging reflective practice on our spiritual and pastoral encounters. It was suggested that we shared this example with readers of JHCC.

Initial interaction

'Claire' was a patient for some weeks on one of the wards at Wycombe. She was referred to me by one of our Chaplaincy volunteers, because she had indicated that she saw her illness as a punishment from God. I had previously spoken to her briefly with her husband, when she seemed too depressed to speak at any length. I had learned that she was suffering from an unusual nervous complaint, which had left her paralysed more or less completely from the neck down and unable to swallow. There was no certainty to what extent, if any, she would recover.

Second interaction

Because the volunteer had told me of her concerns, I was able to reflect and pray about what approach to take before visiting her again. She was still on her own, and although finding speaking a struggle, was very ready to talk. She spoke in a very childlike voice as a result of her illness, which could have tended to affect my reactions and meant it was very important to focus on the content and not the manner of her speech.

Claire quickly raised the idea of her illness being a punishment, as she had with the volunteer, and was expressing self-distaste and something close to despair. It seemed to me that the issue for her was not about God and her understanding of him, but about herself. It therefore did not seem appropriate to question her view of God as someone who inflicts that kind of punishment. She was also not really well enough for that kind of intellectual discussion, and it would not have answered her emotional and spiritual needs. It might have been right to look at why she thought she was being punished and what it was she felt guilty about, but as I spoke with her that also felt too intellectual, and while it might have helped resolve some of her personal issues and problems, it seemed destined to fail to connect with her needs, especially spiritual needs. What I did was to talk about forgiveness and God's power to forgive any sins, and the fact that we are all valuable to him. I asked Claire if she would like me to say a prayer, asking for God's forgiveness, and she agreed. I then offered a prayer which was a simple kind of confession, asking forgiveness, and then pronounced absolution.

Further interactions

The encounter seemed to have taken away her feeling that she was being punished and she gradually regained control of her body. She remained in Wycombe hospital for some

months and I visited Claire regularly, taking her communion and talking about her feelings. She made steady progress and was transferred to another hospital to complete her rehabilitation.

Last visit

About six weeks later I had to visit that hospital to cover for another Chaplain. Claire's name was on the list to be visited and I learned that she was to be discharged later that day. She was actually with her physiotherapist, but I thought she would like to see me, so I tentatively asked in the Physio department if it was all right to put my head round the door. She was absolutely delighted to see me, and said that my visit had been the turning point and she had started getting better from that moment on. She said that I had such a serenity about me.

My response to last visit

My feelings about her reaction were quite complex and raised some issues for me:

- 1) Naturally I was pleased to see her looking so well, walking, with quite good hand control and far more normal speech.
- 2) If I'm honest, I was also glad on the level of personal satisfaction that my visit had helped her so much. Then I felt guilty because I was feeling pleased with myself and her gratitude seemed to be fulfilling my own needs by improving my self-image.
- 3) I was also quite surprised; her recollections of our second meeting (the one I described above, which ended with me pronouncing absolution) seemed more significant and dramatic than mine and I wondered why this was. What aspect of the experience had I missed, either at the time or since, with her or indeed with other patients?

Further reflection

The two areas I feel the need to reflect on are:

- how do the pastoral interactions with Claire compare with others in my daily rounds?
- how did her comments relate to and affect my self-perceptions?

It strikes me that what made this pastoral encounter different from many others was that I was clearly involving God in the process. Sometimes I treat him as a sleeping partner for whom I am acting as an agent. I think it helped a lot that I was prepared for the meeting with her by the volunteer's referral. I am quite good at reacting intuitively and can be sensitive to needs, but I sometimes rely too much on this (on my own strength) when I feel the need to respond quickly, instead of giving myself unhurried time to consider prayerfully the best approach.

This encounter reinforced for me the good that can come from taking time to reflect before acting. Many of our patients are in hospital for a while and it would be possible to take a situation away with me to think through, and then return, rather than trying to offer an immediate solution. I have always seen spiritual care as ongoing, but what I am suggesting here is a more deliberate postponing of a spiritual discussion (when practicable) until I am sure I have done all I can, to be as well equipped to engage in it as possible.

Claire's perceptions of the encounter and of me, and my reaction to these, also raise a number of points that I have been reflecting on:

- Firstly, for me, our second meeting was very much part of an ongoing relationship, and I had not seen it as such a 'turning point', although when I recount the facts as above, I can see that it clearly was and am very surprised that I did not spot it before. There are also some obvious parallels with the story of the paralysed man in Mark 2. Why did I not see such an aspect of healing taking place? Was it a natural humility that I did not expect to be used in a 'miraculous' way, or quite the reverse; a form of arrogance in that my focus is too much on what I am doing and too little on what God is doing? (Probably, and paradoxically, a bit of both.)
- Secondly, I realize how important it is to have some affirmation, especially at the moment when I feel challenged in terms of vocation. My initial reaction was guilt that I saw her recovery in terms of my own personal satisfaction, but I am often unsure how much good I am doing, and worry about how much difference there is between what I do and what any hospital visitor would do. On reflection, I think it is natural and healthy that I felt good at having got something right.
- Thirdly, I found her description of me very interesting – 'such a serenity'! This is not the first time such phrases have been used about me in my role as Chaplain, but I do not think they ever have in any other context. I have frequently said that I must be the only person who can work hard at being laid back! I do want to come across as quiet, serene and calm, and believe I actually am on the inside. A friend once described me as like a cappuccino – all froth on top but quite deep and still underneath – and I do believe being a hospital Chaplain draws on such qualities. I want to develop this aspect of myself within my healthcare ministry, and also to access it in all areas of my life, although I'm not yet sure how. I need to identify some reading material about this and pursue with both my supervisor and spiritual director.

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CONTEMPORARY PILGRIMAGE

Revd Stephen Bushell is Senior Chaplain with the Buckinghamshire and Oxfordshire Mental Health NHS Partnership Trust and a Jungian psychotherapist in private practice.

Abstract

While respecting and acknowledging the need for Chaplaincy to define itself within the NHS in this time of transition, I aim, by way of narrative, to promote our role as accompanist to the developing journey of meaning-making in the lives of the people we meet. Life narrative is crucial to this process, particularly bringing to consciousness those moments of the turn to the inner life that bring insight to the depth meaning-making process.

Main Article

Tell them stories ... You must tell them stories, and everything will be well, everything. Just tell them stories, (Pullman, 2000 p.455).

Tim¹ greeted me with a declaration: 'Steve, I just need to warn you that we might get shot. It's a really dangerous place we are going to'. He was clearly quite frightened, so I decided a comical show of being prepared might be helpful. Mimicking a cowboy, I assured him that my pistols were loaded and we had nothing to fear. So we set off in the car with a laugh, but also acknowledging that for Tim the prospect of our trip was spiritually fearful: our excursion to his father's grave would entail a re-interment of memories three decades old, and it could prove painful.

Tim and I had known each other for four years, from an inpatient stay after his mother's death. More recently, we had been meeting monthly to talk about this bereavement, which had unsettled him at a deep level. Having found a way of leaving Mum where she now is, and honouring her place in his life by regular visits to her grave in the local town cemetery, Tim had begun to express the need for a return to his lost father and with that a return to his own origins in London. We had set a date, had spent some time looking at the road map and thinking through the places he wanted to visit. Without stating it as such, the itinerary had been assembled for a personal pilgrimage.

Tim's father's grave was in a large London cemetery. Tim hadn't been back for 30 years. Having no family and no one he could ask to accompany him on this visit, I had suggested that we might go together. As the day had approached, Tim (who had been diagnosed as schizophrenic in his twenties) had become anxious – not least because a number of people had been telling him that he was planning to visit a dangerous area of London.

My task was to be the driver and pilgrim accompanist. Tim proved to be a brilliant navigator and I had need neither of the road map nor of my battered copy of the London

¹The person's name has been changed to secure confidentiality but permission has been sought to publish this for a wider readership.

A-Z. It was a great joy for Tim that he still knew his way around: 'I'm still street-wise after all these years,' he said.

Approaching our first stop, Tim was busy pointing out numerous places of earlier reference for him and his family – the shops he used to go to for his Mum, the pubs he'd visited with his mates and his dad, the important bus routes (but how he missed the old Routemaster buses).

We parked in a road between four high rise blocks of 1960s' flats. There were few people about. We stood on the pavement. Tim lit up a cigarette. I couldn't help feeling what a link that was with his youth spent here. He pointed out the flat where he had lived with his mum in his late teens and twenties. The changes in detail were noted – the different lettering on the block names. More importantly, the stories came to life: 'We used to sit on that wall...I used to walk across that walkway to my mate's...Mrs Y used to live there. She was really kind to us ...' For a moment I experienced a powerful feeling of unity, of Tim then and now. I told Tim that I was moved, being in this place with him.

Tim found the courage to go into the block to find his old front door and to see if the same neighbours were still there. I left him to do this alone – not only because I didn't want to pick up a parking ticket, but also because this seemed to be an opportunity for Tim to be alone. Two children emerged from the concrete block, walking with their mum towards a car that had pulled up. For them the pavement became a race track and the two small figures – tiny in this setting of towering concrete – set the place ablaze with their smiles and whoops of laughter; even the potholed road was momentarily shouting for joy. Called back, they got in the car which drove off. Life was bursting out in those children, not yet suffocated by the oppressive environment of their upbringing.

Returning some minutes later, Tim reported the details of change – new front doors, for example. He offered more snapshots of memory – who had lived on their landing, what it was like in the lift, what you could see from the window.

Back in the car, we drove on, but back in time. Tim navigated us through a labyrinth of streets until we came to the road of his infancy and pulled up outside his first home. Again the detail was found, this time in the front gate and in the colour of the front door, which remarkably had not changed. We sat and looked, and I was moved to comment: 'Here is the front door through which your mother took you home after your birth ... Here is the gate that led you out into the world ... This is the street where you met your first friends.' 'Yeah,' Tim uttered, caught up in his own reverie of the moment.

Driving on past more landmarks we came to the cemetery, a vast terrain of weeds choking crosses and tomb monuments, all hidden behind a wall, separating the vale of death from the busy high street. We got out of the car. Tim's sense of place remained strong: 'We walked with the coffin along this path. At the end we turned right and Dad was buried near a tree.' We re-trod that path together, but Tim had an intuition that the grave stone wouldn't be there. I searched around but Tim was clear about where his dad was buried. Disappointed that the grave was no longer marked, he said: 'But I've come back to the place where he is buried and that is what matters.'

It was time for another communion smoke. We lamented the sense of ruin in the cemetery and sought to distinguish vandalism from decay. Death was in the very fabric of the place. We drove out beyond the wall onto the busy road. I mentioned that it felt like we were emerging from another world. Tim confirmed that was his feeling too, how his past felt like another world that he had reconnected with.

On the way home through the heavy traffic we stopped for a coffee, each of us acknowledging a feeling of tiredness. Tim felt a little heavy. We talked about the process of reconnecting. He suddenly said: 'I wish I had stayed in group therapy now.' 'When was that?' I asked. 'In the seventies. My doctor had said that was my best chance. He was a really nice man'.

After his dad had died his psychiatrist had had referred him for therapy. He had good memories of this psychiatrist and spoke warmly of him. The pilgrimage of reconnecting had brought him back to a man who had cared for him. I noted to myself that the journey had returned him to a healing figure. We talked about the timing of things – maybe the seventies had not been the right time for his therapy.

After some time of silence in the car, Tim said: 'I've been back. I won't need to do that again.'

A few days later Tim telephoned and suggested that one day he could show me his mum's grave in the local cemetery. 'We've got a nice plot there,' he said.

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CREATIVE PIECES

On Being Called

A poem written after being with several dying patients and their families in fairly rapid succession.

*Invited, to join the crowd in death's ante-room
Supposed, that priestly authority brings –
familiarity, assurance, knowledge.
Here is someone who knows.
Who speaks words; of meaning to chaos,
hope to despair, faith to doubt.
Who will hold aside the shadow of the veil,
ease the passage to eternity.*

*Instead we collude together, hiding
discomfort, dismay, despair.
Speaking of distances travelled,
past pleasures, to mask future pain.
Convinced that the dying will heed our voices,
fill the spaces threatened by fear with the noise.
Is death to be but another experience
which answers no questions?
The departing, falling, haphazardly through the veil.*

*If we allowed the silence,
Acknowledged the awe-fullness of death
Would not then the voice of eternity,
audible only in truth,
bring meaning, hope and faith?
Instead, leaving,
turning away from the presence of death,
Feels like a betrayal, a failure of expectations.
Invited, but an ill-trained Master of Ceremonies.*

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Not 'Caring for the Spirit', but 'The Spirit for Caring' – A Sonnet

*How can we measure those things of worth
Which counting denies, through counting's measure?
How can we rule that which we love
When ruling confines and constricts what we treasure?
For in the measure, our giving's curtailed,
In the count, our calling retailed.
Statistics use defines our conventions
And turns 'being-with' into 'interventions'.
But when we sit with those who are dying,
Or vigil night-long and hold the crying;
Or in the darkness hear pain running deep
We touch God's face and hear him weep.
It's then we must love, with love our goal,
For if statistics win, we lose our soul.*

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'Uninvited the guest comes': a brief introduction to the poetry of R S Thomas.

Tom Harris is a part-time Chaplain at the Norwich Community Hospital. Having recently completed an MA in Christian Spirituality he is presently participating in an Internship in Spiritual Direction at Loyola Hall for which he has received a CHCC bursary.

*She came to us with her appeal
to die, and we made her live
on, not out of our affection
for her, but from a dislike
of death. Her face said she looked
in that stone face; its vocabulary
made her tongue dry. Her breath
was that on one keeping afloat
over bottomless fathoms; and we waved
to her from the solid shores
of our own flesh. The ambulance came
to rescue us from the issues
of her body; she was delivered
from the incompetence of
our conscience into the hospital's
cleaner care. Yet I took her hand
there and made a tight-rope
of our fingers for the mis-shapen
feelings to keep their balance upon.*

The Echoes Return Slow, p77.

The attraction of R S Thomas's poetry is that it is so chewable, and that even, perhaps especially, when we disagree with what we perceive to be the sentiments of a poem, we have been given something to think about, to mull over.

The nameless poem above, which records the death of the poet's mother, is as good a place to start as any by way of introduction to a substantial body of inspirational and very usable poetry. R S Thomas, Welshman, poet and priest, wrote an average of a poem a fortnight for more than 50 years. His ministry was mostly in rural rather than urban settings and, as an Anglican priest in a Methodist world, he felt very much the outsider. His poetry so very often puts into words one's experience and, because he wrote reflectively until shortly before death in his eighties, he offers the discerning reader the possibility of a glimpse into an older person's spirituality. Just as Attars, 'The Conference of the Birds' resonates with mystics beyond the Sufi world, so Thomas's search for the hidden God offers food for thought to Chaplains not of the Christian faith.

Collected Poems 1945 – 1990 represents a valuable introduction to R S Thomas. His early poetry includes themes which the English reader may not initially find helpful.

His poetry in praise, and despair, of Wales may grate. Then there is a character, Iago Prytherch, with whom Thomas seems to converse in verse. Leafing through *Collected Poems*, there are those which could cause the novice to put the volume back on the book shelf, yet Thomas rewards patience and effort. Even Prytherch stands for an important element in Thomas's (and possibly our) spirituality, along with the notion of 'gap'. Let me explain.

Thomas longed to be Welsh through and through, yet his earliest years were spent in England. His mother was the ward of an Anglican rector, and he grew up speaking only English. His father was three times absent to Thomas: physically, in childhood, through his work as a seaman; then again absent through the disappointment of not becoming a skipper; then finally absent through his profound deafness. Thomas never communicated with his father as he wanted, and this, together with his early childhood outside Wales and his inability, until later, to speak Welsh, contributed to the sense of 'gap' which runs through his poetry.

This sense of 'gap' which Thomas experiences as standing between him and his parishioners occurs also in his relationship with God. God is the *deus absconditus*, the God who is there by not being there, and for whom R S Thomas will wait by the sea's edge. For the sea is also important to Thomas. Indeed, the two extremes between which Thomas finds himself in tension are those of the *via positiva* and the *via negativa*. Thomas sees in the sea and bird life signposts to God but finds that when he seeks to draw closer, God seems to draw away, only to be found when Thomas is about to give up. In this, R S Thomas echoes the experience of the writer, or editor, of the Song of Songs:

*Upon my bed at night
I sought him whom my soul loves;
I sought him, but found him not;
I called him, but he gave no answer.*

*The watchmen found me,
as they went about the city.
'Have you seen him who my soul loves?'
Scarcely had I passed them,
when I found him who my soul loves.
I held him and would not let him go.*

Song of Songs 3:1, 2b-4b.

*To one kneeling down no word came,
Only the wind's song, saddening lips
Of the grave saints, rigid in glass;
Or the dry whisper of unseen wings,
Bats not angels, in the high roof.*

*Was he balked by silence?
He kneeled long,
And saw love in a dark crown
Of thorns blazing, and a winter tree
Golden with fruit of a man's body.*

'In a Country Church', *Collected Poems* p.67

After a lifetime of ministering and preaching Thomas retires. He wonders: were his poetry, and the reflection behind or beneath it, just for the sake of having something to say from the pulpit on a Sunday? This seems not to be the case since some of his finest poetry is composed in the years following retirement and deals with older person issues like the death of a spouse and his own departure.

R S Thomas's poetry offers its readers the possibility of feeding on images which have the power to transport them out of the cages of the expectations and previous experiences. He offers unusual ingredients to which we bring the yeast of our own experiences and questionings, and out of which a new (for us) image of God and our relationship is born. The constant theme of pilgrimage, that quest for the Holy Grail of God's presence and his meaning for our life, is an inescapable, though often unacknowledged, fact both of our and our patients' spirituality. There is seldom a short cut to authoritative witness, nor any substitute for a living spirituality which has embraced the desert.

*Moments of great calm,
kneeling before an altar
Of wood in a stone church
In summer, waiting for the God
To speak: the air a staircase
To silence; the sun's light
Ringing me, as though I acted
A great role. And the audiences
Still; all that close throng
Of spirits waiting, as I,
For the message.
 Prompt me, God;
But not yet. When I speak
Though it be you who speak
Through me, something is lost.
The meaning is in the waiting.*

'Kneeling', *Collected Poems*, p.199.

The desire to be helpful, friendly, offer that pearl of wisdom, can seduce most of us into speaking when really we would have been better keeping silent. Often what we have to offer is indigestible in one sitting – and we know we may not get another chance. But:

*Enough that we are on the way,
never ask us where.*

*Some of us run, some loiter,
some turn aside*

*to erect the Calvary
that is our signpost, arms*

*pointing in opposite directions
to bring us in the end*

*to the same place, so impossible
is it to escape love. Imperishable*

*scarecrow, recipient of our cast-offs,
shame us until what is a swear-*

*word only become at last
the word that was in the beginning.*

'The Word' *FRIEZE*, 1992, *Schondorf am Ammersee*.

The persistent reader of Thomas's poetry may come to share with Thomas that understanding that the God wrestled with all night and who escapes our hold as dawn breaks is the God who loves us enough to engage in the combat. The strife is not a sign of God's displeasure but of God's seduction of the objects of his love. A M Allchin puts it well when he writes:

We receive the world from God as a gift. But it can only be ours in so far as we are prepared to renounce it. To grasp it is to lose it ... God's regard brings with it a "deep but dazzling darkness" ... And in this darkness the soul grows within, silently and unobserved, within, the flower of the divine life unfolds, a flower whose roots are not in the soil, whose petals are not coloured with the hues of sea and sky, a life which is born not of the flesh nor of the will of man but of God. Man finds within himself an inner heaven and earth, a sky whose immensity is greater even than that of the sky without. And this sky is shot through with the rainbow sign, the sign at once of God's absence and God's presence, which speaks alike of storm and sunshine, and which assures us of the mystery that both in darkness and in light God makes himself known, establishing his covenant with all that he has made.

AM Allchin, 'Emerging'.

There is a flavour to some of Thomas's final poetry, a feeling that he waits for death to come knocking and is surprised to be kept waiting. Fully aware of his own destiny his last volume, *No Truce with the Furies* opens with 'Geriatric':

What God is proud
of this garden
of dead flowers, this underwater
grotto of humanity,
where limbs wave in invisible
currents, faces drooping
on dry stalks, voices clawing
in a last desperate effort
to retain hold? Despite withered
petals, I recognise
the species: Charcot, Meniere,
Alzheimer. There are no gardeners
here, caretakers only
of reason overgrown
by confusion. This body once,
when it was in bud
opened to life's kisses. These eyes,
cloudy with rheum,
were clear pebbles that love's rivulet
hurried over. Is this
the best Rabbi Ben Ezra
promised? I come away
comforting myself, as I can,
that there is another
garden, all dew and fragrance,
and these are the brambles
about it we are caught in,
a sacrifice prepared
by a torn god to a love fiercer
than we can understand.

No Truce with the Furies, p.9.

So many of those we serve seem to come to the end of their lives with a sense of bewilderment, a disbelief in the facts of their situation, and a feeling of dissatisfaction with the bad decisions or lack of achievement which appears to sum up their life. Increasingly frail and isolated by the death of friends and family, to what may they look forward? For Thomas it is summed up in these words published shortly before his own death:

*When we are weak, we are
strong. When our eyes close
on the world, then somewhere the bush*

*burns. When we are poor
and aware of the inadequacy
of our table, it is to that
uninvited the guest comes.*

Laubbaum Sprache, p.62.

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Reference;

Allchin AM (1978). Emerging: A Look at some of R.S.Thomas's More Recent Poems.In:

Ansley S. (Ed.).(1992). *Critical Writings on RS Thomas*. Seren, Bridgend.

Thomas RS (1995). *Collected Poems 1945 – 1990*. Phoenix, London.

Thomas RS (1988). *The Echoes Return Slow*. Macmillan, London.

Thomas RS (1998). *Laubbaum Sprache*. Babel, Tel-Aviv.

Thomas RS (1995). *No Truce with the Furies*. Bloodaxe, Tarnet.

Lest I forget.

I find the following lines from William Wordsworth's 'Ode to Intimations of Immortality' enormously helpful to recall in my work with forensic patients who not infrequently have suffered abusive childhoods.

*. . . Our birth is but a sleep and a forgetting;
The Soul that rises with us, our life's Star,
Hath had elsewhere its setting,
And cometh from afar;
Not in entire forgetfulness,
And not in utter nakedness,
But trailing clouds of glory do we come
From God, who is our home:
Heaven lies about us in our infancy!
Shades of the prison-house begin to close
Upon the growing boy;*

*But he beholds the light, and whence it flows,
He sees it in his joy;
The Youth, who daily farther from the east
Must travel, still is nature's priest,
And by the vision splendid
Is on his way attended;
At length the man perceives it die away,
And fade into the light of common day.*

*Earth fills her lap with pleasures of her own;
Yearnings she hath in her own natural kind,
And, even with something of a mother's mind
And no unworthy aim,
The homely nurse doth all she can
To make her foster-child, her inmate, Man,
Forget the glories he hath known,
And that imperial palace whence he came. . . .*

*. . . Full soon thy soul shall have her earthly freight,
And custom lie upon thee with a weight
Heavy as frost, and deep almost as life!*

Amar Hegedüs
Chaplain and Imam
South London and Maudsley NHS Trust
Developing Organisation & Community
Spiritual & Pastoral Care Service

BOOK REVIEWS

As I said in the editorial, can I draw your attention to our appeal for more book reviewers? We have a backlog of books awaiting review – hence the reduced number in this edition, and you do get to keep the book you volunteer for ...

Simon

At the breaking of the bread – homilies on the Eucharist

Edited by Patrick Jones

2005

Veritas Warehouse, Dublin

ISBN 1853909106 £14.95 159pp

After Vatican 11, the altars were turned round and priests began to celebrate Mass facing the people. This often meant that the priest would have his back to the tabernacle, which contained the reserved sacrament. One elderly professor commented: 'Oh I don't like the idea of turning our backs on Christ in the Blessed Sacrament'. To which another younger and quick witted professor retorted: 'Ah, but how do you know he is not sitting in there with his back to you?' 'Oh, I never thought of that' came the response.

Indeed, Eucharistic discourse within the Church has always been a sensitive topic: often over-devotional, theologically defensive, narrow and subject to many rules and regulations. But things have changed and developed over the years. The Scriptures became a source of inspiration when they were no longer read in Latin and our lectionary today gives us plenty to tuck into. Yet, sometimes, even the Scriptures can become dry and tiresome. 'If you cannot think of anything to preach about on the readings, you can always fall back on preaching on the Eucharist' a priest friend once told me in my earlier years of priesthood. This little book, which was inspired by the 'Year of the Eucharist' which came to an end last October, reminds us that in giving a sermon the Eucharist should be more central to our ministry of preaching the Word.

I suppose these 35 short homilies by 14 different people are mainly directed to priests, especially in parishes, and editor, Patrick Jones constantly uses the word homily, a word I like very much myself. I always imagine that the homilist 'brings home' the message in a warm and gentle way, as if to make the message 'homely'. Though the editor tells us that the homily is 'an exposition of some aspect of the readings from Sacred Scripture or of another text from the Ordinary or from the Proper of the Mass of the day and should take into account both the mystery being celebrated and the particular needs of the listeners' (General Instruction of the Roman Missal 65).

Opportunities for a homily about the Eucharist are quite obviously numerous. For example, the Feast of Corpus Christi, Holy Thursday, First Holy Communion, the Sundays of Mark's Year (B) – 17th to 21st in ordinary time, on John's Discourse of the Bread of Life, to name just a few.

The majority of the homilies are on the whole practical and related to everyday life. There are one or two which could be described as meditative and more suitable to quiet reflection. However, they all provide a source of personal contemplation and may be adapted as one feels fit. The homilies certainly give us something to think about. The book is divided up into sections, with differing themes: The Lord's Day, Eucharist and the Human Condition, Thanksgiving, Real Presence, Word and Sacrifice, Bread of life and cup of Salvation, Service, Eucharist and Justice, and Eucharist and Mission. The homilies are all based on various liturgical readings and the texts are specifically identified for easy reference.

I am sure that this will be of great benefit to most priests.

Reveiwed by Andrew Graydon

Parish Priest and Mental Health/Hospice Chapain, The Presbytery, Mexborough.

Health Care and Christian Ethics

Robin Gill

Cambridge University Press, Cambridge

ISBN: 13 9780521857239 £45.00 pp145.

If you have ever sat on a clinical ethics committee and wondered what you are doing, this is the book for you. Arguably essential reading despite its price, it addresses a key concern: can a Christian perspective make a significant contribution to public health care ethics?

In pluralist and multicultural Western societies, secular philosophers and academic lawyers dominate a discipline once the preserve of Christian theologians and hospital chaplains. Gill argues that secular accounts of health-care ethics are philosophically impoverished by 'moral gaps' which ignore the reality of morally inept communities, post-modern dependence on 'personal resonance'; and humankind's natural inclination to selfishness. These are gaps which Gill believes presents Christian theologians with an opportunity.

Theologians, coming from communities steeped in traditions of moral soul-searching, bring to the debate concerns for interpersonal relationships and justice. Such differences may be relative and theologians, at times, may bargain away their principles, but for Gill the Judaeo-Christian tradition offers distinctive virtues which engage with modern health-care ethics: virtues he unravels from the Synoptic Gospel.

Unfortunately, this unravelling process leaves me uneasy. Partly, it is the way Gill searches for key Christian virtues by analysing patterns of behaviour trawled from healing stories. Obviously, Gill is delving into an academic area not his own, but the vintage of some of the scholarship he cites raised questions (Robinson 1957; Taylor 1959; M'Neile 1965; Barrett 1967). From patterns of behaviour between Jesus and those he engaged at times of healing, Gill chooses specific behaviours which, he maintains, reflect fundamental Christian virtues. How does he make his choice? Literally, by counting the number of times each behaviour occurs. But what does Gill do when the same healing story is reported more than once? A full weighting for what he considers to be a primary source and a half weighting for what is supposedly a secondary account. Somewhat crude, as Gill himself admits.

Yet despite the problematic methodology, the second half of the book is excellent as Gill considers virtues of compassion, care, faith and humility in the context of health-care dilemmas.

Compassion is explored as that virtue which trumps principled scruples. While not an answer in itself, compassion provides incentive, energy and commitment to action absent from Beauchamp and Childress-type 'thin' principles. The ethics of maintaining a person in a Persistent Vegetative State reminds us that ethical principles exist to serve people and not the other way around.

While labels such as health-care, community care and care assistants suggest care is an integral part of secular medicine, Christian 'care' digs deeper, recognizing that on occasions care and compassion are incompatible. The Gospel story of the Prodigal Son illustrates how compassionate care for one son causes the other to feel bitter and resentful. Correspondingly, those living with HIV/AIDS have a right to compassionate care, but the need to control and prevent transmission of the disease may dictate a 'caring' political and social response, focused on the common good and at odds with individual need. Duty of care to an HIV/AIDS patient may conflict with a duty to protect potential partners.

Faith, as a virtue, stands out because of where Gill takes us. He claims that while faith needs to be present in the doctor-patient relationship, recent years has seen its gradual demise. Gill points to O'Neill who argues that a desire for accountability (and audit clearly demonstrates this) has delivered cynicism, shattered confidence and kindled mistrust. The secularist, Durkheim, recognized that religious rites and beliefs encourage people to think beyond themselves and to embrace altruism. Indeed, evidence suggests that religious-belonging makes for improved mental and physical health. Where does this lead Gill? To endorse the importance of hospital Chaplaincy – no bad thing from our point of view!

Then there is humility, notably absent as doctors claim too much and patients demand too much. The tragic truth is simple: there is an inherent imbalance between demand and supply in a publicly funded National Health Service. Gill quotes Verhey to good effect: 'The truthfulness necessary to acknowledge tragedy and the humility necessary to cope with it can be sustained by piety, for piety knows it is God, not medicine, who brings in a new age' (p.201). It is humility and justice that necessarily form the bedrock of equitable health-care provision in Western societies.

Gill's reference to Gordon Dunstan reminded me that almost 40 years ago, I sat at Dunstan's feet during a meeting of the Institute of Medical Ethics in Edward Shotter's London flat. Dunstan and Shotter ensured that the Church's role was taken seriously as modern health-care ethics became established. Today, the Church's stand is more equivocal and that is why Gill's book, and his unequivocal thesis, is so important. The Church's championing of compassion, care, faith and humility can complement, deepen and perhaps challenge secular health-care ethics. These virtues are not unique to Christianity as Gill acknowledges. They have an established presence in other world faiths, but therein lies another book.

Anthony Kyriakides-Yeldham

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The following two books have *not so far been reviewed by chaplains. However, the brief review by Keith Nicholson of Jessica Kingsley Publishers indicates they would be of value to many chaplains so are included for your interest. You may wish to offer a fuller review – in which case – get in touch with us directly.*

Medicine of the Person: Faith, Science and Values in Health Care Provision

Edited by John Cox, Alastair V. Campbell and Bill (K W M) Fulford

Foreword by Julia Neuberger

2006

240 pp

ISBN 1 84310 397 4 £17.99/US\$34.95

Paperback

Medicine of the Person is an international, multi-faith exploration of the demonstrable need to integrate the scientific basis of healthcare more fully with spiritual, religious and ethical values.

Informed by the principle of 'medicine of the person', the contributors argue for a medical practice which takes account of personal relationships, spirituality, ethics and theology in keeping with the ideas and beliefs of Paul Tournier, an influential Swiss general practitioner whose thinking has had a substantial impact on routine patient care relevant to national health services. Bridging the gap between the basic sciences and faith traditions, the contributors discuss notions of personhood in different faiths and its consideration in spirituality and mental health issues, general practice issues, public health, home care for the elderly and neuroscience.

This volume offers a broad spectrum of approaches to the needs of patients and is a key text for students of the health disciplines, and practitioners and managers in these fields.

Making Sense of Spirituality in Nursing and Health Care Practice – An Interactive Approach

2nd edition

Wilfred McSherry

Foreword by Keith Cash

2006

216 pp

ISBN 1 84310 365 6 £14.99/\$24.95

Paperback

Caring for the spiritual needs of patients is a highly significant, yet often neglected and misunderstood aspect of health-care. This results, in part, from a general lack of guidance and instruction given to healthcare professionals on the subject.

This new edition of an established introductory guide to spirituality and health-care practice draws extensively on case studies illustrating the application of theory to practice. It encourages the exploration, through reflective activities, of what spirituality means, both to patients and to the healthcare professionals caring for them.

This book provides a comprehensive introduction to spiritual care for health-care professionals in all areas of practice.

LETTERS TO THE EDITOR

20 July 2006

Re: Your recent article in the CHCC journal (Vol 7:1)

Dear Dr Swift,

May I congratulate you on your re-election as president of CHCC. I read your recent article with interest and am writing to offer further clarity to some of the issues you raised in respect of the Caring for the Spirit Strategy.

The Caring for the Spirit Strategy does not suggest that there is a need 'for current Chaplaincy staff to re-train on a template drawn from clinical pastoral education' as you say on page 60, paragraph one. The wording used is 'current staff members to re-train and new members to develop ...' and this refers to NHS staff who are not working in Chaplaincy and, by implication, are not chaplains. The section on training (paragraphs 113 to 123, CfS) goes into greater detail than the conclusion section from which you have drawn your quote.

The former South Yorkshire Workforce Development Confederation and South Yorkshire Strategic Health Authority developed project management processes based on calls for evidence from a wide range of healthcare and associated bodies and there is currently a small project management infrastructure based on project management good practice. I feel that it is therefore misleading to suggest that the strategy relied 'or the chief part of its development on staff based in Church House and the inclusion of selected chaplains by invitation' as you say on page 60, paragraph two.

The structure of the written output draws upon the content of strategies already in existence within the NHS. Membership of the project groups was by invitation and all were members of the College of Health Care Chaplains or senior staff in associated organizations which could support this development. The chief part of strategy development was in the synthesising of submissions and the listening exercise with chaplains and others.

It is disappointing that you feel (page 60, paragraph two) that in the development of the strategy there was the assumption 'that chaplains would have little choice other than to sign up to the end product and swallow its limitations without appreciable criticism'. The project group made no such assumptions, seeking comments on a draft strategy in accordance with best practice guidance including circulating the draft widely and arranging discussions of the draft around the country. The draft was changed as a result of these discussions and of the written comments received from the College amongst others.

Similarly, the process of development had not 'sought to sidestep the growing political maturity of Chaplaincy while engaging in a form of what might best be described as managerial professionalisation' (page 60, paragraph two). The project group did not 'sidestep' anything and did not engage in 'managerial professionalisation' as this has no meaning within the project.

The strategy document clearly shows that several Chaplaincy bodies submitted evidence to this review including the College which also commented on the draft papers. I am glad you drew comparison with Scotland and Wales. The English and Scottish health systems are different and the status of documents reflects the view of Governmental policy (Page 60, paragraph three).

The strategy has not 'chosen to pursue largely historic and conservative patterns of working' as you say on page 60, paragraph four. The strategy has had to follow a lead based on the evidence it received, and has done so faithfully. This includes the evidence and commentary from the College which, as you know, welcomed the strategy on its publication. The ongoing implementation of the strategy fully takes into account that the NHS as a whole, Chaplaincy in particular and society in general are evolving and therefore the framework contains the flexibility to meet current and future needs. The recent guidance paper on the different models of working highlights that a wide range of working patterns have been drawn to the attention of chaplains and allows for individual Chaplaincy team circumstances to be taken into account.

I hope that the above comments help in clearing up some misunderstandings you appear to hold relating to the Caring for the Spirit Strategy and its implementation. In order that the readers of the Journal may have similar opportunity to read my comments and gain a clearer understanding I am copying the letter to the Editor of the CHCC Journal asking that this may be published in the Journal. I am also copying it to Revd Mark Folland who is on the staff of the Caring for the Spirit project and also on the editorial board of the Journal.

Yours sincerely,

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Instructions for the Submission of Articles to *The Journal of Health Care Chaplaincy*

If you wish to discuss an article before submission, please contact the editor by email or on 07811 437553. We seek to include a balance of subject areas (e.g. palliative care, mental health, professional practice, etc), as well as a range of styles, from academic/evidence-based work to reflective/experiential articles. Our main articles can be as substantial as 3 – 4,000 words, while shorter articles are welcomed between 750 and 1,500 words. Articles will be blind reviewed within or beyond the editorial team, and feedback can be provided on request, whether articles are accepted or not.

- Articles should be attached to an email and sent to 'journal@hospitalchaplain.com' or on a disk in Word format. Please attempt to emulate the style you find within the most recent edition, although we may amend to enable consistency.
- Each article should have a clear title; author or authors with the professional capacity in which the article is presented; the hospital and/or academic institution to which the author(s) is/are attached and in what capacity:

e.g. Revd Jim Dobson, Chaplain, University of Dovedale, Hodness Hospital, Worcester, Postcode, UK

- Contact details should be provided for correspondence, ideally including an email address. Contact details/work email will be published with the final article to encourage discussion. Let us know if you do not wish this.
- Complete articles or extracts may be published in electronic form through the CHCC or related journal website. Please indicate clearly at submission if you would not wish your article to be published in this form.
- Articles should be headed by a short abstract/summary. You may also indicate 'keywords' if you wish, e.g. personhood; interdisciplinary; spirituality; pastoral care, etc.
- References should be provided and a (selective) bibliography.
- Authors of academic articles should use the HARVARD SYSTEM of referencing (see pp.90 – 91; if in doubt, consult with the editor).

Help with the Harvard System

- In the text of your article you should give the author's name and then the year of publication in brackets.

e.g. Smith (1997), suggests that for most doctors, pain is viewed as a physical problem to be dealt with by physical methods.

- If you are referencing an article that is written by two authors, you include both authors' names in the text and then the year in brackets.

e.g. Mitchell & Jones (1989), comment that in recent years, the special knowledge and abilities of Chaplains have extended into the fields of chronic pain control and the control of pain in labour.

- If you are referencing an article, which is written by more than two authors, you write the first author's name and then in italics write *et al* instead of other names, followed by the year in brackets.

e.g. Masterman *et al* (1997) performed a study to examine the contributions of salient behavioural, contextual and developmental information.

In such cases you include the first three authors names in the reference section followed by *et al*.

- If you use referenced material to support your comments, the references will conveniently appear at the end of the sentence in chronological order.

e.g. A number of authors have suggested that the management of spiritual pain should reflect current researched evidence (Mitchell & Dean 1990, Hadjistavropoulos *et al* 1997, Jones-Williams 1999).

- At the end of the article all the publications cited should be listed alphabetically by surname of first author. The following should be included:

If you are referencing a book, provide:

- The name of the author(s)/editor followed by the initials.
- The year of publication in brackets.
- The book title which should be in italics.
- Edition (if not the first).
- The publisher's name.
- The place of publication.

e.g. Bowling A (1997). *Research Methods in Health: Investigating Health and Health Services*. Open University Press, Buckingham.

If you are referencing a contributor in a book provide:

- The name of the contributor.
- The title of the section of chapter.
- The relevant page numbers.

e.g. Wilson RE (1996). Transcutaneous Electrical Nerve Stimulation. In: Leflowitz M, Lebovits AH with Wlody DJ, Rubin SA. (Eds). *A Practical Approach to Pain Management*. Little Brown and Company, Boston. P136-141.

If you are referencing an article, provide:

- The name of the author(s) with initials.
- Date of publication in brackets.
- The title of the article.
- The name of the journal (which should be in italics).
- Volume (in bold), number (if available) and page numbers (separated by a hyphen).

e.g. Notcutt WG (1997). What makes acute pain chronic? *Current Anaesthesia and Critical Care*. **8**, 2, 55-61.

If you are referencing a thesis or dissertation, include:

- The details of level and the name of awarding institution.

e.g. Name (year). Title. Unpublished MSC dissertation, Cardiff, U.W.C.M.

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Authors of previously published articles may submit a 'review' article of 750 (maximum) words with details of the original publication, date, page number and number of references.

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