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EDITORIAL

Simon Harrison

Before discussing the articles in this edition, can I thank all who have taken up the challenge to write and submit material they see as directly relevant to our contemporary situation. The short piece of research that Maureen Turner has carried out into the dispensability of Health Care Chaplains is exactly the sort of timely piece I was asking for in my last editorial. If we believe (and I do) that the days of justifying our role on the basis of anecdote or personality are over, then many more pieces of research such as this will need to be carried out to satisfy some Trusts. Further, we cannot simply seek to justify our profession 'as it is' without looking to different models of delivery and role, which can adapt to the wider changes within the NHS. Peter Richmond's extensive study of the ability of local faith community leaders to work as partners with Mental Health Trusts in supporting recovery offers an evidence base from which to do just this. Those of us working in Mental Health have an urgent need to respond to the seismic changes in service delivery. With so much more care being transferred to community settings, delivery based on in-patient numbers will be woefully inadequate within months, not years. Peter's research offers some evidence that partnership models of working are possible and safe. I look forward to a 'new norm' evolving rapidly which protects the distinctive role of chaplaincy professionals working across in-patient and community settings, whilst more fully engaging faith communities in the ways Peter would hope.

Engaging with faith communities of course may mean, for some, a need to listen once more to the language of faith as applied to health. Many of you will be aware that Jane Williams is doing some theological reflection in this area, and we hope to bring some fruits of this to you at a later time. Meanwhile, Catherine Sourbut's article offers her personal theological reflection on what chaplains do, written explicitly from the perspective of an ordinand in training looking at God's activity within her chaplaincy placement. I will be interested to hear how some of you feel hearing your work described in this way. It would be nice to get some letters to the Editor for the next edition!

I'm pleased that we are able to share with you some details of the chaplaincy art project from the Sheffield Care Trust. Whilst its context was Mental Health, the model of working is far more widely applicable, whether this involves chaplaincy hosting the employment of an artist or smaller scale projects we might adopt to get the ball rolling. I remember a happy year working with glass paints and a range of patients with learning disabilities to create the 'stained glass window' that beautifies my office. It led to good interaction with several people who wouldn't touch my religious services and never wanted a cup of tea and a chat. If you have recently undertaken something equally creative, please do consider writing up a shorter piece on this and sharing it more widely.

The last two substantial pieces relate once more to research. Bruce Pearce has been a regular contributor to this Journal over the years, and shares with us his thoughts on how

we might further engage in multidisciplinary research projects, based on his own journey in Canada. Graeme Hancocks home-grown research looks in considerable detail at the use of prayer boards in hospitals. I hope after reading this piece we will be encouraged to pay greater intention to this aspect of our work in terms of use and presentation. Society is changing, as are its ways of communicating and praying. Perhaps we should all pay the same attention to our prayer requests as we do to any other artefact of ministry (liturgy, chapel, etc). In today's 'business card' world, what does it say about our respect for a prayer or the value it has to God if we offer scrappy bits of paper?

Looking back through past editions, I reckon this to be my thirteenth editorial. Some things have changed considerably; production has been immeasurably improved both through the meticulous hours Meg Burton spends preparing the final draft and the attention to detail and energy put in by Amar. Having a wider editorial team is what makes the Journal work. Another significant change has been in the style and range of articles. This is the result of individual chaplains and teams daring to submit their work for publication, and I am always grateful for submissions, even if they do not ultimately result in publication.

In recent editions we have sought to subject all submissions to blind review when appropriate. It has proved difficult on occasions to identify the right person to do this (understanding of process, time, relevant specialism, etc). At our spring editorial meeting we decided to invite readers to consider offering themselves as blind reviewers by way of a 'panel' which we can turn to whenever suitable. Chaplaincy is a small world and sometimes authors are too well known to easily 'blind', but the more we follow this discipline, the better the quality. Blind reviewers can also support authors in improving or resubmitting articles. If you would like to be considered, please contact me or any of the editorial team in the coming weeks.

My second request is slightly more demanding. Mia Hilbourn, who has been on our editorial team since Volume 6, has had to step down to balance her commitments, and her clear insight and ability to encourage authors will be greatly missed. It is therefore time to strengthen the editorial team further. Although we have palliative care experience, we do not have anyone operating within a hospice environment. With Mia's departure we have a glaring need for at least one more chaplain with acute general and/or team leadership roles. We are also aware that for a long while we have not had a Scottish or Welsh member on the team. Could I therefore invite people to contact me in the coming weeks to find out more about what this role entails (three year term, renewable whilst in chaplaincy post, encouraging articles, advising team on articles in your area of specialty, etc). I would love to be able to put several names before the team for consideration this autumn so we can develop a balanced membership. I'm aware that for some the commitment to be on the editorial team may seem onerous, and we might consider having a reference panel if you are willing to support the quality of the Journal but cannot make our editorial meetings two or three times a year. I must reiterate how important this support is for continuing the life of this Journal.

The editorial team always appreciate your feedback on the content of each edition, and you can always do so via JHCC@hospitalchaplain.com

With warmest regards,

Simon Harrison

Devon

April 2007

WHY DO WE NEED HEALTHCARE CHAPLAINS IF CLINICAL STAFF DELIVER SPIRITUAL CARE?

Maureen Turner was Chaplaincy Team Leader at Leicester Royal Infirmary.
Ruth Lambert is Chaplain at Leicester General Hospital.

Abstract

This paper seeks to address some of the issues arising from the cuts to chaplaincy services in Worcestershire and other NHS areas. It particularly addresses the question of who is best placed to deliver spiritual care to patients and their visitors. It presents the results of research undertaken at Leicester into the preparedness of doctors and nurses to offer spiritual support to patients and visitors. The findings are discussed and evaluated, particularly in terms of future planning for training in the provision of spiritual, pastoral and religious care, with some conclusions and suggestions for future development.

Keywords

Chaplain, Chaplaincy, Spiritual, Religious, NHS training

Main Article

Introduction

The plan to 'save' chaplaincy services in the Worcestershire Acute Hospitals NHS Trust may be applauded as a short-term solution, but the whole debate has sent worrying shock waves throughout the country. Chaplains are urged more than ever to record and collect data to use as evidence under threats of cutbacks.

One aspect of the early decision to cut services that was particularly irritating for some chaplains, was a statement that we were no longer required as spiritual care givers because doctors and nurses were able to offer spiritual care to patients. It is to this comment that we offer some thoughts for discussion.

Straw Pole

Recently a chaplain led a training session on Chaplaincy Services to medical students at a local university. Not wanting to miss an opportunity to hear their views, a straw pole was included as part of the teaching¹. Asked if they felt qualified in meeting the spiritual and religious needs of patients, the overwhelming conclusion was 'no' for the following reasons:

- Spiritual care is a specialism that chaplains have which is much deeper than a doctor's own personal belief

¹ The following scenario was discussed: 'The Trust have decided to disband chaplaincy services in your hospital. One of the reasons given (apart from saving money) is that doctors and nurses are well able and qualified to meet all the religious and spiritual needs of patients.' Though this straw pole cannot be regarded as serious research, it gives an example of one way in which chaplains can introduce the value of chaplaincy at an early stage in a doctor's career, thereby widening and furthering the debate.

- Doctors do not have the necessary skills
- Doctors do not have enough time to handle individual spiritual needs
- Doctors have their own specialisms, which they are expected to use and develop

Most chaplains would agree that a certain amount of spiritual care can and should be given by all members of the hospital care-giving team, including doctors. Saunders (2001)² comments:

'I would use the word "spiritual" as being wider than the purely more structured "religious." We need to keep a better look at that whole aspect of which a great many people, particularly nurses and doctors, and social workers for that matter, find a difficult area to address. But a lot of it is done indirectly and I think some of the things that are happening such as the way the care is given, can reach most hidden places and be a spiritual comfort when no words are exchanged.'

What we might question, however, is the lack of in-depth training and thereby lack of knowledge, experience and specialist skills if clinical staff are to provide the best spiritual care to patients. Also under question is how to ensure that the unique role of healthcare chaplains is valued and recognized as fully complimentary to the roles of other professional caregivers in delivering both spiritual and religious care.

Survey amongst doctors and nurses

Background

During Summer 2005, the Chaplaincy Training and Research Committee (CTRC) was formed at the University Hospitals of Leicester. Its aim is to improve and develop existing training courses given by chaplains to healthcare staff and volunteers. Already, within two years, benefits are being reaped, as demonstrated by well-attended courses and a national conference. In Autumn 2005 CTRC undertook a survey amongst qualified and practicing doctors and nurses, in order to help identify any specific training needs that they might require to equip them in assessing and meeting patients' spiritual needs. The responses received provide a valuable snapshot of the experiences, opinions and conclusions of the staff that replied. This provides interesting data that has direct relevance to the subject of this paper, since it provides some evidence about the provision of spiritual care to patients and visitors. The UHL context is of three large acute teaching hospitals, set in the spiritually and culturally diverse East Midlands city of Leicester, although the patient intake naturally draws from a wide geographical area. Some of the staff's survey responses reflect this varied context.

Method

The survey was in the form of a questionnaire. Senior Nurse Managers received these internally by e-mail and then printed and distributed hard copies for nurses in their area. When completed they were returned directly to the Chaplaincy Department. – 202 replies

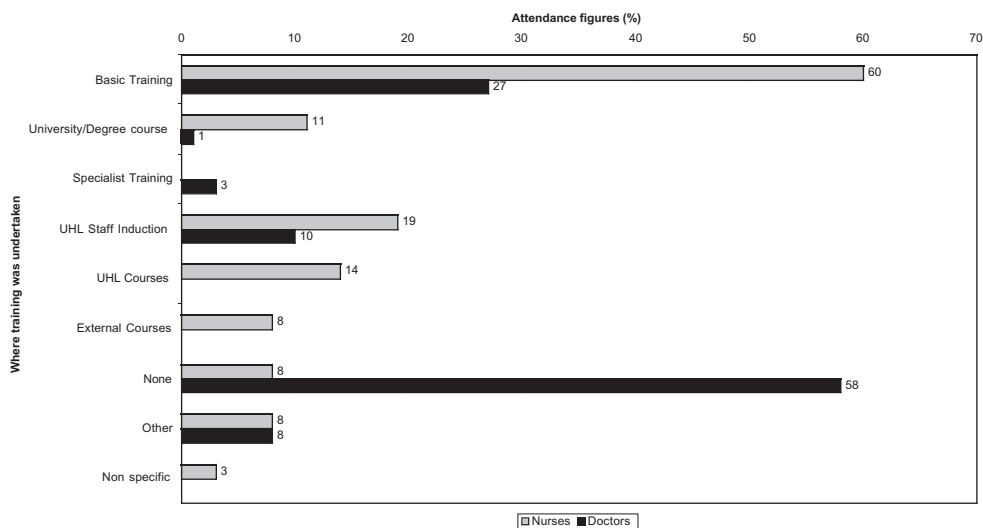
² Cicely Saunders in M Turner (2001). *Continuity and change in Hospice and Palliative Care*. Unpublished MA dissertation, Leeds University.

were received (21% of those sent out). Doctors received hard copies through the internal post using an up-to-date database held by the Clinical Education team – 73 doctors replied (12% of those sent out).

While the returned questionnaires naturally reflect the experiences and individual viewpoints of the responders and therefore cannot be taken as universally representative, the collated results can be used to inform future training provision by all involved in spiritual care provision.

Four questions have been selected for discussion and the results are shown in the tables below.³

Question 1: Where did you receive training in spiritual and religious care?



Of those who received no training, comments from nursing staff included:

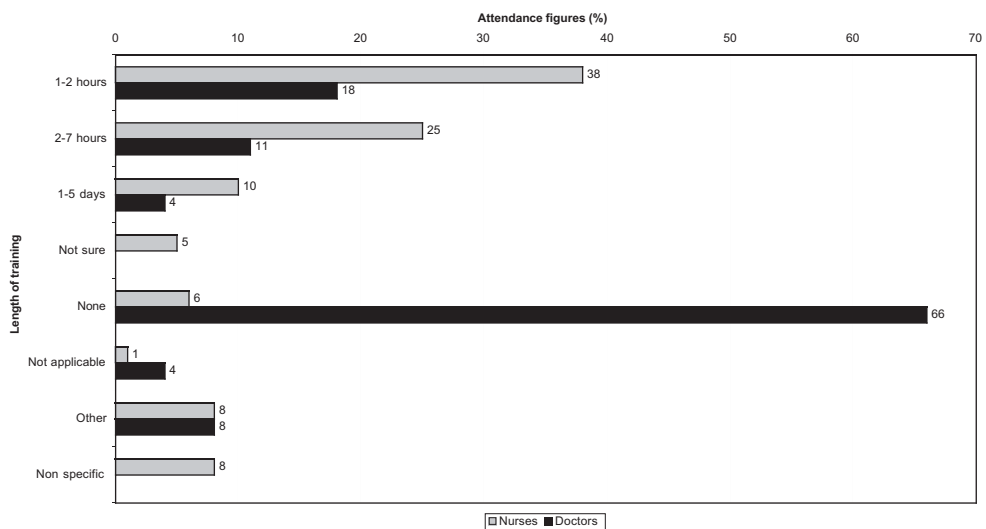
- 'I did my nursing in India, I have not received training in spiritual and religious care'
- 'I grew up in a Christian home'
- 'School and church'
- 'My sibling is a religious leader/scholar'
- 'Own Christian beliefs (trained in 1966)'

³ Note: the first two questions gave multiple choice options

Several doctors commented that their knowledge of spiritual care came through other means, including:

- 'Own experience and church'
- 'Working with LOROS'⁴
- 'During palliative care'
- 'Literature and working with the faiths'
- 'At home'

Question 2: How much time was spent on spiritual and religious training?



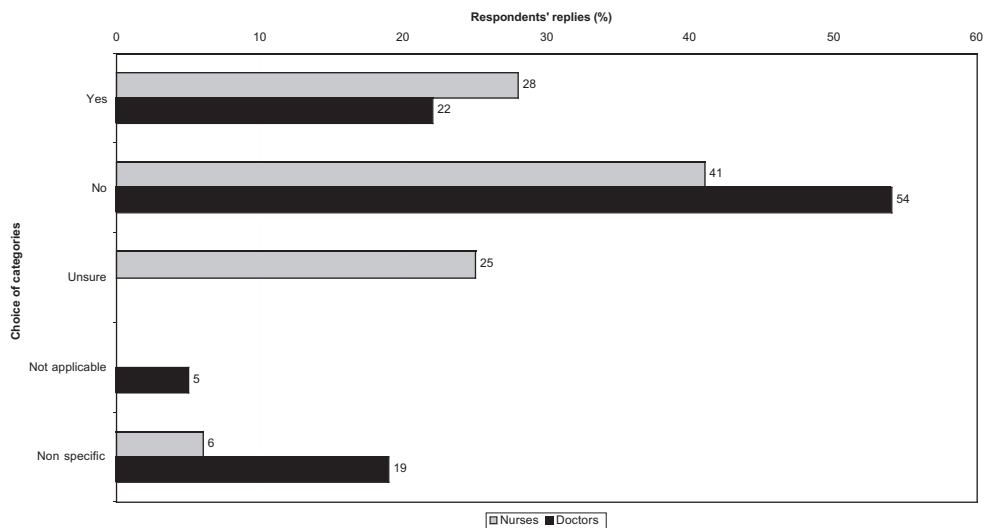
Nurses' comments for clarification included:

- 'Whole module at university'
- '1/2 hour'
- 'Did training in religious and holistic counselling'
- 'As part of NVQ'
- 'Lifelong church member'

Doctors' comments included:

- '15 minutes'
- '3 months'
- 'Theme throughout medical school'
- 'None in the hospital'
- 'Lifetime'

Question 3: Do you feel adequately informed and prepared to meet the spiritual needs of patients?



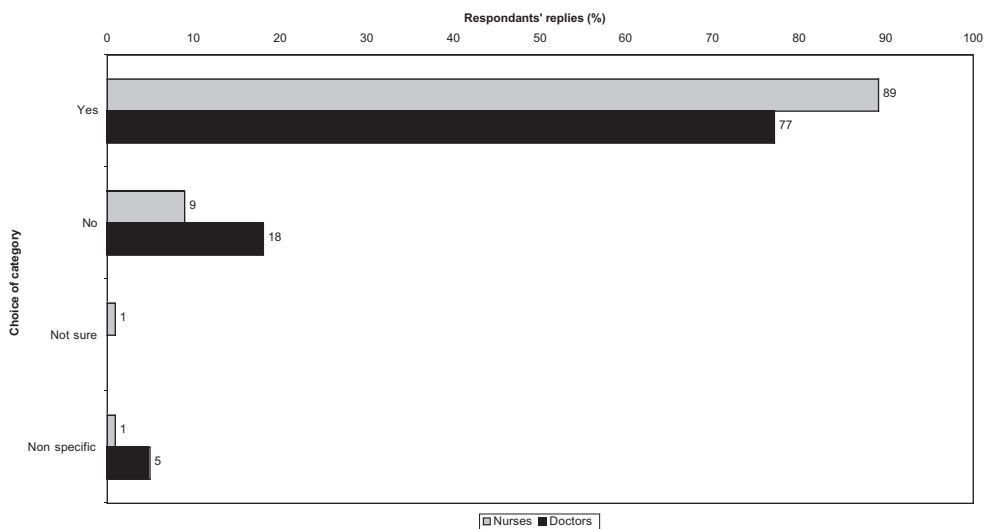
Comments from the nurses included:

- 'I've lived in Pakistan and India, Muslim and Hindu countries'
- 'Need more information regarding the spiritual/religious needs of other cultures within Leicester'
- 'Need updating as we deal with clients from many religious practices'
- 'Have not had time to access all training opportunities due to work commitments'
- 'Too big a subject, but can do the basics even if it is asked what is of value to you in your life'
- 'I have a broad understanding, but people's needs are complex and individual'
- 'The most important thing is knowing who to contact for advice'
- 'I feel happier calling the chaplaincy. I know there is someone always available'

Doctors' comments included:

- 'We rarely need to enter into discussion with patients, re: spiritual/religious care'
- 'Able to offer support/empathy and refer on'
- 'We just use our 'common sense' – I guess'
- 'Spiritual – no such thing, psychological training adequate'
- 'Implied by Medical School that although relevant – not 'as important' as physical well-being'
- 'No – 'cos never had training!'
- 'I would like at least basic understanding of faith/beliefs of different cultures found in the hospital'
- 'I do know how to access people and information who could help'

Question 4: If time allowed, would you attend further training courses in spiritual and religious topics?



Comments from the nurses included:

- 'Possibly not relevant at this stage'
- 'Specific needs of patients re: care in theatre and care after death'
- 'Spiritual care of relatives'
- 'Would be interested in cultural/religious diversity only'

Comments from doctors included:

- 'Learnt now through experience'
- 'It is a subject often lost in the constant strive of doctors in training to learn and pass exams'
- 'Perhaps, best to catch doctors late in training/young consultants, when they begin to think more holistically'
- 'No, but interested in spiritual care of the dying.'
- 'Not at present, but if time allowed I would find the role of a healthcare chaplain, spiritual care of the dying and cultural/religious diversity helpful.'⁵

Discussion of issues raised by survey results

The results give a clear and somewhat alarming indication of shortfalls of doctors' and nurses' spiritual and religious care training, especially during their basic training years.

It is obvious that the nurses receive more training in religious and spiritual care than doctors. The high percentage of doctors who receive no training in religious and spiritual issues could be perceived as disturbing, considering how much contact and influence they have with wards, nurses and patients. However, it is interesting to note that both groups stated a similar range of preparedness, with around 20–30% of both doctors and nurses feeling 'adequately informed' and 40–55% 'inadequately trained'. It is encouraging that 89% of nurses and 77% of doctors stated that they would attend further training sessions if offered.

The results have also uncovered shortfalls regarding the quantity and quality of training in spiritual and religious care received. The overall impression given is that most clinical staff are either lacking in basic spiritual care, knowledge and experience or think it is not their concern. The considerable majority of trained clinical staff responding felt uncertain about either their own ability to offer spiritual/religious care or about its value within the general delivery of holistic patient care. This clearly has direct implications for patient access to the appropriate spiritual/religious care to which they are entitled.⁶

What can we learn from this?

Summary

The question remains as to whether the spiritual care offered to patients by clinical staff can adequately replace specialist provision by chaplaincy or spiritual care departments. Our survey reveals a large degree of uncertainty amongst the medical profession about their willingness or preparedness to offer such support, while the nurses surveyed generally expressed more confidence. However, it is encouraging to note that large percentages of both professions were interested in learning more about religious and

5 These were some of the proposed training themes that Chaplaincy could offer medical staff.

6 See Government guidelines on NHS provision, for example, statements such as: 'All NHS Trusts provide spiritual support for patients, staff and relatives through chaplains and faith community representatives.' Department of Health (2003). NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff: Guidance for managers and those involved in the provision of chaplaincy/spiritual care. 5.

cultural practices to improve their care of patients and relatives. This, of course, takes no account of the wider chaplaincy team role in delivering, for example, staff support, consultancy and advocacy within the institution.

Whilst valuing therefore the contributions from many clinical professionals in providing a certain level of spiritual care during patient contact, they themselves recognize the limitations of their roles as non-specialists in spiritual and religious care, citing some of the following factors:

- a) Clinical staff do not receive in-depth training in spiritual and religious issues as part of their basic training
- b) Where individuals request introductory or specialist courses, time constraints can prevent in-depth teaching or may result in non-attendance
- c) Clinical staff are already over-stretched in maintaining and developing their own healthcare specialisms
- d) The extra pressure, stress and expectations placed upon them in taking on the role of spiritual caregivers would be crippling and impossible to sustain
- e) Holistic care involves a multidisciplinary approach and requires experts from all fields of healthcare practice, including spiritual/religious care specialists

Moving forward

This study provides some evidence that there is an urgent need within healthcare institutions that chaplaincy services should be proactive in:

- a) Helping trusts fulfill their obligation to provide good spiritual and religious care to patients, families and staff of all faiths or no faith
- b) Encouraging and where possible enabling staff training in the awareness of spiritual and religious issues
- c) Communicating the presence and value of chaplaincy services and publicizing methods of referral
- d) Developing and sustaining links with related Trust departments, local universities and medical/nursing colleges
- e) Providing spiritual, pastoral and religious care out of hours
- f) Taking responsibility for monitoring its own service provision and finding ways of assessing need and evaluating effectiveness

In conclusion, this piece of research, although limited in its scope and application, highlights some of the many issues faced by healthcare chaplaincy departments at present. There is clearly a pressing need for further evidence-based research to be undertaken by chaplains, and we would want to encourage the sharing of insights gained. Perhaps as data is gathered similar findings will emerge. The benefits to chaplaincy and our Trusts could be enormous. We encourage you to widen this discussion!

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FAITH COMMUNITIES AS PARTNERS IN MENTAL HEALTH PROMOTION AND SUPPORT FOR RECOVERY FROM MENTAL ILLNESS: RESULTS FROM A SURVEY OF FAITH COMMUNITY LEADERS IN THANET, KENT.

Peter Richmond is Lead Chaplain, Kent and Medway NHS & Social Care Partnership Trust

Abstract

There seems to be continuing resistance among mental health service providers to work with faith communities as partners in care. This article draws on the authors' study, *Caring for the Mental Health of your Congregation*, exploring relevant attitudes, beliefs and actions among a group of faith community leaders in Thanet, Kent, to provide a better understanding of how stakeholders in mental health promotion and recovery strategies can work with faith communities.

Twenty-one faith community leaders answered a series of questions that revealed their experience, knowledge, attitudes, beliefs and actions in relation to pastoral care around mental health and health promotion, both for members of their congregations and for those they encounter as visitors and occasional callers.

The results evidence a sound base for responsible partnership with these respondents. High levels of respect for autonomy are indicated and existing commitment to care. There is also considerable scope for raising mental health awareness, particularly around the issues of patronization, opportunities for equal participation and recognition of capacity for contribution by experience.

If space permits we hope to publish detailed methodology in a later volume.

Main Article

Introduction

Faith communities are increasingly cited as contexts for tackling stigma in mental health and opportunities for social inclusion. Mental health and spirituality are frequently noted as having connections for the benefit of mental health service users and in health promotion. Faith communities offer resources for the promotion of mental health generally, and the support of people with mental ill health specifically. These resources benefit faith community members, including those who may be users of mental health services as well as people who are in mental and emotional distress and who find their way to faith communities in times of crisis. The availability and the quality of those resources depend considerably on the willingness and the ability of individual faith leaders to work in partnership with service users, carers and service providers.

Methodology

Despite the limitations recognized in using a questionnaire it was decided to be the best method of reaching the faith communities of Thanet, a combined leadership of about 70 persons.

The majority of questions were framed in such a way as to invite the respondent to describe in their own words, their own thinking on each issue. It was important that respondents communicated in their terms and used their own forms of interpretation. As one possible use for this study is to improve partnership working, service users and service providers need to be able to 'hear' what faith community leaders are actually saying about mental health issues as they see them. It was also considered more likely that respondents would best reveal their true feelings, if they are allowed to use their own language, theology and health constructs.

Results and discussion

The population group and the respondents

Overall, from the 73 faith community leaders sent questionnaires, 21 were returned, a response rate of 29%. Multiple returns came from the Baptist, the Church of England and the Roman Catholic churches. Individual returns came from three Free Church denominations and two other faith communities. A third group comprising two large international Free Church denominations and 14 much smaller individual faith communities were sent questionnaires but did not return any. Whilst it is true that 29% is a reasonable return for a postal questionnaire, it is also true that 66% of the faith community traditions did not respond. This survey therefore represents some of the views held in six mainline Christian traditions, plus one Islamic faith community and one post-modern faith community.

Table A : Return results and faith designations of respondents

	Sent	Of All Returned	Denominations
Totals	100% (73)	29% (21)	100% (24)
Group 1	56% (41)	76% (16)	13% (3)
Church of England	30% (22)	38% (8)	
Roman Catholic	19% (14)	24% (5)	
Baptist	7% (5)	14% (3)	
Group 2	12% (9)	23% (5)	21% (5)
United Reformed	5% (4)	5% (1)	
Methodist	3% (2)	5% (1)	
Evangelical	1% (1)	5% (1)	
Muslim	1% (1)	5% (1)	
Post-modern church	1% (1)	5% (1)	
Group 3 (nil returns)			66% (16)

Experience of mental illness, training and risk

This question used a tick box method to gain information regarding:

- Respondent's self-assessed experience of diagnosed mental illnesses.
- Respondent's interest in learning more about any of those illnesses.
- Respondent's approach to risk management linked to those illnesses.

Table B: Level of experience of mental illness, interest to learn, attitude to risk

Disorder	Some experience	Interest to learn	Risk – yes	Risk – no	Risk – not sure
Alcoholism	81% (17)	5% (1)	71% (15)	5% (1)	5% (1)
Bipolar disorder	57% (12)	19% (4)	62% (13)	5% (1)	14% (3)
Dementia	81% (17)	10% (2)	52% (11)	24% (5)	5% (1)
Depression	90% (19)	10% (2)	57% (12)	19% (4)	5% (1)
Drug addiction	62% (13)	5% (1)	67% (14)	0% (0)	5% (1)
Eating disorders	52% (11)	10% (2)	29% (6)	24% (5)	14% (3)
Obsessive compulsive disorder (OCD)	48% (10)	14% (3)	52% (11)	10% (2)	10% (2)
Personality disorder (PD)	52% (11)	14% (3)	76% (16)	0% (0)	0% (0)
Schizophrenia	62% (13)	19% (4)	71% (15)	0% (0)	0% (0)

There is a high level of self-reporting knowledge, with experience with depression, dementia and alcoholism recording the highest. Less common mental illnesses still recorded experience levels that were higher than perhaps would be expected in the general population. There was a low response in terms of 'interest to learn', although 19% expressed an interest in knowing more about bipolar disorder and schizophrenia. There was a high level of risk awareness for personality disorder, schizophrenia and alcoholism. And 24% considered that eating disorders and dementia did not give rise to risk issues.

Respondents profess to have a fair degree of knowledge and understanding of mental illness, with experience with depression, dementia and alcoholism recording the highest. This would connect with the evidence given that for most of them, the pastoral care of people with mental illness is a normal and fairly frequent part of their professional lives. It was surprising that even the more obscure diagnoses scored relatively highly for experience (lowest score OCD scoring ten, Table B above). As expected, depression scored the highest for experience, but it also scored four for no risk. This might indicate that there is some lack of risk awareness and about depression and suicide.

Respondents showed little inclination to learn any more about mental illness. The most interest came from four respondents who expressed an interest in knowing more about bipolar disorder and schizophrenia. Given respondents are a group of people who have showed some interest in mental health by returning the questionnaire, this low result could indicate an even lower interest in learning about mental illness and mental health

issues in the wider community of faith leaders. However, a few respondents did show interest, which suggests that offering training should be done on a wider geographical basis targeting those who show a particular willingness.

In terms of approach to risk, most respondents indicated that they would take action, in terms of their response to people, if they knew that they had a diagnosis of mental illness (Table B). High-risk scores may be due partly to fear and stigmatization, but they may also be due to a raised awareness amongst professional clergy that they have to comply with codes of conduct, child protection legislation and health and safety regulations at work. High scores would also be in line with the fact that a large number of the respondents were used to regular encounters with people, not part of their faith community, who appear to them to have mental illness (*See below*).

Amongst people suffering bipolar disorder, drug addiction, OCD, personality disorder and schizophrenia, there was a higher register of risk than there was of experience. This might indicate that respondents are influenced by popular fears about mental illness; equally, it could be taken that where there is a lack of knowledge it is prudent to increase risk precautions. Conversely, for a group of people who put old age problems at the top of their problem list, and 17 of whom had experience in dementia, only 11 of them considered dementia to have a risk factor, and five indicated that dementia presented no risk. Injuries by falls and accidents are relatively common amongst people suffering from dementia. Perhaps respondents consider mental health risk primarily in terms of untoward behaviour rather than physical frailty. PD received the highest risk score.

Understanding the implications of mental illness to people who suffer it

This asked for observations regarding the problems that people face who have mental illness. This question was designed to raise empathy, and to draw respondents towards the outcomes of mental illness rather than its aetiology or medical interventions. As can be seen below, respondents measured consequence of mental health primarily in sociological and psychological terms. Spiritual consequences slightly outweighed the medical consequences, but neither was given the same weight as the first two.

Table C: How respondents observed consequences in terms of four domain descriptors

All Soc. references	86% (18)
All Psy. references	67% (14)
All Sp. references	24% (5)
All Med. references	14% (3)
Confused with LD	5% (1)
No answer given	5% (1)
Total	100% (21)

Respondents acknowledged heavily the distress and the isolation that accompanies mental illness: *'Not being able to function within a 'normal' church setting; feeling unable to participate; not good enough to be there; difficulties in making relationships'*. For a few, it is recognized that mental illness has an effect on the spiritual lives of those who suffer. Rarely do respondents acknowledge the struggles of people with mental illness in coping with the problems of medication and being on a treatment plan. This would indicate that while mental health awareness is good around what they observe, it is evident that service users do not talk to respondents about the medical side of things to faith leaders.

The wider context of disability and need: Is mental illness a priority in faith communities?

This question was designed to put the people respondents had begun to think about into the context of the wider community where mental illness is but one of a whole range of problems people face.

Table D: Total disabilities and social needs as observed by respondents among their congregations and communities in order of ranking

Problem identified in ranking	Total Scores
1 Old age problems	90% (19)
2 Socio/economic	76% (16)
3 Physical Illness	67% (14)
4 Social isolation	57% (12)
5 Mental illness	52% (11)
6 Learning difficulties	24% (5)
7 Drugs and alcohol	24% (5)
8 Physical needs	14% (3)
9 Asylum needs	14% (3)
10 Family problems	14% (3)
11 Abuse	5% (1)

Mental health problems came fifth in the list of first order problems (see Table D above), after old age problems, socio-economic need, learning difficulties and physical illness. Family problems are mentioned only infrequently. Among overall demands and most pressing problems, mental health needs are there, but they are not the respondents' most pressing concerns.

Running through the results is a small but persistent confusion between mental illness and learning disabilities. Some respondents confuse the two; others clearly differentiate. It is a significant detail that in four congregations LD scores are the highest need priority. This said, in a congregation with a large minority of people with LD, it is likely that they could be the first priority for support and inclusion care.

The questionnaire did not set up its own scale around the mental health/mental illness spectrums, ie good to poor in mental health, and neurotic to psychotic in mental illness. There was also nothing to assist people in avoiding confusion between LD with mental illness in supporting information. Respondents used their own terms and definitions. Inevitably, for some, mental illness meant only 'severe and enduring mental illness'. For others it was a clearly a very broad term including problems at a neurotic level. This is how things are in the general population. Mental illness is also often confused with LD and often the other way round, too. Perhaps it would be helpful to make it clearer to faith community leaders how mental health professionals tend to distinguish between disorders which are less common, and problems which are both more prevalent (which ought to make them look for training, and where incidence levels will be likely to make them an everyday encounter for a faith leader with a large congregation). Also for those who need to be reminded, the difference between learning disabilities and mental health disabilities would be an important aspect of training.

Understandings of mental illness: defining through common models

This asked respondents to describe mental illness in their own terms. The study was particularly interested to see whether respondents used biomedical terminology and how much they used more holistic or whole person approaches.

The majority of respondents used psychological terms (76%), as well as medical (67%) and sociological terms (62%) to describe mental illness. And 14% used spiritual terms to describe mental illness, with 5% not answering.

Clearly, respondents do see mental illness as a medical issue. However, they do not see it wholly in medical terms. Indeed, there was not a single response couched in medical terms only. This observation indicates that it is likely that respondents would take seriously the medical implications of mental illness, to encourage people to take their medication where it had been prescribed and to participate in programmes of care. They have not, though, taken up the psychiatric medical model, which allows the diagnosis to dictate treatment, understanding and social expectations (Swinton 2001). Respondents seem fully aware that the psychological and the social are equally definitive. The issues of community and communication indicate that the boundaries of illness, for these respondents, is primarily relational and not medical, and that like most relational problems, their aetiology is not best approached by power of causation but more by process of evolution.

The pastoral care of people with mental illness in the congregation

This question looked for evidence to support the hypothesis that faith leaders have regular pastoral care for people in their faith communities with mental illness and mental health problems.

Responses were analysed as to whether pastoral care for people with mental illness was a normal aspect of their work (N) or an unusual aspect of their work (U). The frequency of care was measured as: daily, weekly, monthly, occasionally. The categories of care offered were designated as: support, counsel, practical care, referring on.

Table E: Pastoral care for members of the congregation with totals for normalcy, frequency and type of care

Total frequency	100% (21)	Total N/U	100% (21)
Daily	5% (1)	Normal aspect	71% (15)
Weekly	43% (9)	Unusual aspect	14% (3)
Occasional/Bimonthly	48% (10)	N/U not given	14% (3)
Confused with Q7	5% (1)		
Kinds of response	100% (21)	All Support	90% (19)
Support	38% (8)	All Counsel	43% (9)
Counsel	5% (1)	All Refer	24% (5)
Counsel/Support	19% (4)	All Practical	14% (3)
Support/Refer	14% (3)	All Groups	5% (1)
Counsel/Support /Practical	10% (2)		
Coun/Sup/Pract/Ref/Group	5% (1)		
Coun/Support/Refer	5% (1)		
No answer	5% (1)		

The majority of respondents regard pastoral care for people with mental illness as a normal part of their work. Support is frequently given and counselling is commonplace. A minority offer this care in terms of referring to others or organizing groups. The frequency rate given is 43% at weekly and 48% at occasionally. Whilst the majority of respondents saw their responsibilities in terms of support, some also considered that counselling was part of their work. There was some acknowledgement that referring on to others was important (five respondents). Only three acknowledged that they offered practical help.

Amongst professional counsellors and mental health practitioners, the term 'counselling' is usually reserved for professional counsellors. That a number of respondents consider that they offer counselling indicates that there would be a gap between the understanding of counselling from the point of view of health professionals and that of the respondents. It would have been helpful for this study to have asked the question: 'Have you any qualifications in counselling?'. It is disappointing that only a few respondents mention practical help. Where help is offered it is clearly done out of a great deal of commitment. *'Have spent much time previously, counselling, etc. Now encouraging "through love" of helping them to grow; as much of mental illness in our group has occurred from previous abuse. Still see, visit and have living with us.'*

Caring for people with mental illness outside the congregation

This asked a similar question to the above, but with the unknown caller or visitor in mind.

Responses were analysed on the basis of frequency of encounter: daily, weekly, monthly, occasionally and categories of care offered: support, counsel, practical care, group/group liaison, referring on.

Respondents reported a high incidence of pastoral care for people with mental illness who are not part of the regular congregation but either call at the leader's home or at faith community premises. In fact, 19% of respondents reported that they had daily callers with mental health and other needs, only 15% said that such encounters hardly ever or never happened to them. The type of care was not always specified, but in 43% of cases some form of care was mentioned. If the group of respondents who gave an answer to this question (17) is taken as the base population, 59% said they had regular encounters of this sort.

Table F : Pastoral care for people with mental illness not part of respondent's faith community, totals for frequency and type of care

Frequency		Type of Care	
Total	100% (21)	Total	100% (21)
Daily	19% (4)	Not specified	29% (6)
Weekly	19% (4)	S/P	14% (3)
Monthly	10% (2)	S/P/G	14% (3)
Occasionally	19% (4)	S/P/G/R	5% (1)
Yearly	5% (1)	C/R	5% (1)
Rarely	5% (1)	S/C	5% (1)
Never	5% (1)	No encounters	10% (2)
No answer	14% (3)	No answer	14% (3)
Confused with LD	5% (1)	Answer confused with LD	5% (1)
Encounters			
Total	100% (17)	Some form of support offered	43% (9)
Regular	59% (10)		
Occasional	24% (4)		
Seldom	18% (3)		

It is significant that ten of the respondents have regular encounters with people not part of their faith community and who have mental illness. For four respondents these encounters are a daily occurrence. For some congregations there is a clear recognition that they have a dual responsibility, not only to care for members of their own group, but also to offer care to the community in which they are set and, in particular, to those in greatest need. *'We regularly encounter people with mental illness as well as other disabilities since our church has an open café on two days a week and also houses an open gathering place under a social service group.'* Some people in great difficulty still look to faith communities as part of their support and coping system. Where there is regular contact, such faith communities should be in regular contact with health and social services for advice and support.

One consequence of the prevalence of mental illness among disadvantaged callers is that mental illness becomes associated with that particular group of people. One reason

why mental illness in the wider population is poorly acknowledged is that, for many people, it is associated with people subject to extreme social deprivation, with whom they do not identify. *'As a monastery, wayfarers come to us for tea, coffee, soup and bread. Many call who are living on benefit and on the fringes of society. A high proportion of these seem to have alcohol/drug-related problems and mental health issues. Typically a dozen such people will call each day, looking not only for food but social interaction and a boost to their morale. Clearly, this is not the case with the regular congregation.'*

Approaches to deliverance ministry

This question was designed to enquire about attitudes, practice and alternatives offered in regard to the authorized practice of deliverance ministry. It was specific in using the terms, emotional or mental distress.

Over half the respondents thought that deliverance ministry could be of help to some people in mental distress. And 33% were opposed to the use of deliverance ministry in these circumstances. However, when it came to actual use the responses are balanced between possible use and rejection of use. All those who considered using deliverance ministry expressed caution in so doing and all but two said that they would refer to others. Two-thirds of respondents said they would offer an alternative form of ministry in preference.

Table G: Deliverance ministry, totals for appropriateness of use, actual use, conditions of use and alternative rites offered

Totals		100% (21)	
Question 1			
Could be of use	Yes	10% (2)	
	Yes equivocal	48% (10)	
	No	33% (7)	
	Don't know	5% (1)	
	Not evidenced	5% (1)	
Question 2			
May use myself	Yes	5% (1)	
	Yes equivocal	38% (8)	
	No	43% (9)	
	Don't know	5% (1)	
	Not evidenced	10% (2)	
Question 3			
Caution and refer	Caution	57% (12)	(All those Y/YEQ in Q2)
	Refer	43% (9)	(All but 2 Y/YEQ inc. ref)
Question 4			
Other ministry offered	Prayer	29% (6)	
	Sacrament	24% (5)	
	Blessing	10% (2)	
	Reconciliation	5% (1)	

Respondents were a very responsible group of people with regard to deliverance ministry. The majority acknowledged that deliverance ministry might, in certain circumstances, be helpful for people in mental distress. *'Very occasionally. I would not suggest it as part of a possible package. I would need clear guidance from God, confirmed by others.'* Some clearly totally disagree. *'Deliverance ministry is, in my opinion, vastly overrated and often abused. I would consider it appropriate in only very exceptional circumstances.'* In terms of using deliverance ministry all but one either would pass the responsibility to the authorized person, or are extremely equivocal about its use. All those who consider the use of deliverance ministry express caution in doing so. All but two said that they would refer to others before doing so. *'As I already said, our faith offers answers to everything in life, but it also asks us to see specialists and knowledgeable people within their respected field. So if someone actually has a mental illness, then they are encouraged to see a doctor. If I understand your question correctly then no, we do not attempt to "heal" people.'* However, this does mean that two respondents indicated that they would be prepared to take part in deliverance ministry with people in mental distress, possibly without reference to others. *'I have seen some awful examples of "spiritual abuse" under the guise of "healing" or "deliverance." However, I am strongly in favour of God-given healing ministry and have seen good results for those in emotional or mental distress.'* In this case, it is not clear whether the respondent differentiates between the two forms of ministry they cite.

Authorized forms of deliverance ministry, for instance, Church of England, require reference to others and should always be conducted after due consultation. That two respondents did not include reference to seeking authorization from others could indicate that there is still some element of poor practice in this area.

There were 14 references to alternative rituals that would be offered, were people to seek deliverance ministry. These fell into three main groups. Firstly, prayer with a person on a one-to-one basis. Secondly, the inclusion of the person in larger gatherings for special healing services that may be held from time to time. Thirdly, the use of the regular sacramental ministry that some Christian denominations practice – in particular, at the Eucharist, through reconciliation (confession) and in the anointing of the sick. In all these rituals and practices there is no implied link between the need of the person and the possibility of external forces from which the person needs to be 'delivered'.

Despite infrequency of practice, this issue still has the power to raise both concern and interest. With these respondents it would seem that people who approach faith leaders believing that their mental distress is due to forces external to the material world are likely to be received with proper care and attention and, in most cases, either receive an alternative ministry or an assurance that deliverance ministry is not appropriate for them.

Approaches to inclusion, contribution, equality and diversity

This question was designed to draw out attitudes around inclusion, participation and the contribution people with mental illness have made to faith and faith communities. Specifically, evidence was sought looking beyond inclusion, to a recognition that people

with mental illness may bring a particular contribution to the diversity of life in a faith community, and a valuing of the same.

In fact 48% of the respondents thought that including people with mental health needs was good to do, on the basis that it was beneficial for the moral and spiritual development of the congregation, while 33% considered that people should be included notwithstanding disability or illness, that people should be treated on an equal basis. Only one respondent considered that the inclusion of people with mental illness might actually bring specific advantages or benefits to their community through that person's learned experience. Most of the respondents made some form of statement regarding inclusion, and only a minority admitted that there were problems associated with stigmatization or patronization.

Overall, responses fell into four main groups. Firstly, there were those who regarded mental illness as having no effect whatsoever on a person's capacity to contribute to the life of faith and the good of their faith community. *'Yes. Not because being mentally ill helps, other than any form of suffering provokes challenges that result in growth, but because often mentally ill people are able to contribute just as effectively as many other people in the congregation.'*

The second group tended to see people with mental illness as offering an opportunity for their congregation to learn something about how they might respond to the needs of others (Cornah, 2006). *'Not a good thing in itself. If facing up to mental illness helps people become more caring and understanding that must be good.'*

The third group recognized that, in some cases, people with mental illness have grown insights that have been profoundly influential for the growth of faith. *'We all have gifts to offer, including the mentally ill. We should listen to them and affirm them.'*

The fourth group would regard mental illness as an entirely negative experience, something to be coped with by both the sufferer and those around him or her. *'This does not really ring true. Alternatively, I have observed great charity on the part of ordinary parishioners towards truly offensive people who, to my mind, are actually mentally and emotionally unbalanced. Such charity seems to me a wonderful exercise of faith.'*

In terms of the balance between these different groups, ten respondents were more on the side that people with mental illness made a passive contribution to the spiritual and moral development of their congregations. Eight respondents emphasised and recognized the importance of individual autonomy and the capacity for people with mental illness to make an active contribution. More respondents included reference to the contribution that people with mental illness made than made reference to the demands that they made on the congregation. Only one respondent referred to problems that people with mental illness face in terms of exclusion from the congregation. Only one respondent recognized that mental illness may bring about insights about life that could be of benefit to others.

Coping and protective factors for mental health within faith communities

This question evaluated knowledge and understanding regarding mental health promotion, both risk factors and protective factors, and how far they were associated with the social, religious and existential opportunities that may be associated with faith life.

The majority of respondents recognized that belonging to a faith community gave rise to a number of protective factors – 66% included sufficient statements to be placed into three or four of the four groups of protective factors used. Belonging to a community and the benefits of social support was recognized by 86%. Intrinsic statements were given by 76%. Religious activities of faith, whether they were informal or ritualized, were regarded as protective by 52%, and 38% thought that belief structure (doctrine) was important. In terms of the total numbers of statements made, community, intrinsic and ritual scores made up 90%.

Although the title for this study refers to mental health, the emphasis has been rather more on mental illness and response to mental illness. All the respondents to this question made a connection between the benefits of belonging to a supporting community and mental health. The majority recognized that intrinsic values were essential to protect mental health. Intrinsic statements included, for example, 'feeling accepted, belonging, loved by God', 'following the commands of our religion to get closer to God'. 'Prayer from the heart' and 'Knowing that Jesus is with you'. These make a direct connection between what is believed/acted on and mental health. A large number of responses include reference to both ritual practice and doctrinal belief, but these should all be held in the context of intrinsic faith.

There is a difference between holding to certain doctrines, practising certain rituals without them making a significant difference to the meaning, purpose and value structure of your life, on the one hand, and holding the same doctrines and practising the same rituals but allowing them to make wide-ranging and significant difference to moral actions, on the other. Intrinsic religion and spirituality, as an indicator of better protective strategy, is evident in this study. Certainly, the respondents' belief is that intrinsic religion and spirituality makes a difference to mental health. In terms of the scores for protective factors, respondents indicated that they recognize that a broad spread was necessary for the better building of mental health. A minority showed a narrow approach.

Understanding of protective factors in the wider community

This was similar to the previous question with respect to risk factors and protective factors for mental health, but looked for recognition of these things in the wider social and personal context – beyond the faith community. Responses here were analysed on the basis of inclusion referring to the following key protective factors: Individual (I); Family/Social (FS); Life Events and situations (LE); Community and Culture (CC) (taken from Commonwealth Department of Health and Aged Care, 2000).

Table H : Totals for protective factors for mental health within the wider community as recognised by respondents

Totals	Number of times referred to	Number of respondents referring to
Total	100% (87)	100% (17)
Individual	37% (32)	35% (6)
Life Events	21% (18)	29% (5)
Family/Social	20% (17)	35% (6)
Community and Culture	18% (16)	47% (8)
No response	5% (4)	N/A

As can be seen, there is a balance of approach to protective factors. Respondents gave an average of 4.8 factors each. While individual factors predominate, others are certainly not neglected. In terms of numbers of factors cited, respondents were able to include several, and in some cases up to the maximum of eight. In terms of groups of factors, there was also a good spread. Most of the respondents included more than one group of factors as important and most, but not all of them were able to avoid including religious concepts in answering this question. However, only three mentioned money or having enough. Only one mentioned comfortable housing and three mentioned a safe place to live.

In *Making it Happen* (DoH, 2001) the following are listed as determinants: equitable access to services and resources; support for parents and carers; activities for community life; effective sharing of information; tolerance and trust; friendly environment; effective dealing with crime and anti-social behaviour; robust local democracy; and opportunities to participate. This research does not evidence nearly so comprehensive a list, but it does indicate that respondents recognize mental health to have important protective factors, material, social and spiritual.

Conclusions

This study's group of 21 respondents represent Faith community life in the middle ground of organized religion in East Kent. Just two minority faith communities are included. However, between them, they have considerable experience of caring for people with mental illness. Interest in further training in mental health care was low. Mental health and mental illness were recognized as mid-range issues for their congregations. Old age problems were more pressing, accompanied by socio-economic needs and physical illness. Mental health issues should, therefore, be included as part of a whole package of support for faith communities, and not raised as an isolated issue.

Respondents' approach to mental illness seems measured and responsible. Attitude to risk is good; empathy and understanding indicators are also good. Understanding of the negative spiritual implications of mental illness was not registered, except in a minority of cases. The respondents took a broadly based approach to mental illness, which balanced the medical with the social and the psychological.

Little mention is made of carers and their needs in the responses. Admittedly this was not explicitly asked for, and is a recognized shortcoming in the design and methodology. However, it might have come up in the section regarding all major problems faced by congregations. Faith communities have an important role in the support of carers, particularly in terms of protecting the mental health of people who are under considerable stress from their responsibilities.

Respondents have wide experience in encountering people with mental illness, both in the congregation and beyond it. There is a considerable degree of variation in terms of care offered. Practical support and group opportunities are evidenced, but most offer support through inclusion in the normal services and programmes of their faith community. Some have a heavy load of callers who are in considerable states of social and mental health distress. How far they are supported by health and social services should be investigated.

Most of the respondents do not associate mental health problems with any aetiology other than the eclectic medical/psycho/social model. Their approach to deliverance ministry indicates that they would differentiate between mental distress, which might have a spiritual aspect and benefit from deliverance ministry, and mental illness, where deliverance ministry invariably causes harm.

Approaches to inclusion indicate that there remains a high incidence of tendency to patronization. Just under half the group were aware of individual autonomy as a prerequisite for an appropriate approach to inclusion. To them, mental illness should not make a difference to the pastoral care they offered. Congregations are congregations, notwithstanding their medical problems. Only one respondent indicated that people with mental illness may have a positive contribution to make to others from their experience of mental illness.

Respondents recognized the contribution their faith community made to coping skills and protection factors for mental health. Community belonging and participation in faith activities are recognized alongside the need to hold faith as an intrinsic element for life. Doctrines are not prominent in their understanding of protective factors. Respondents see faith as integral to the human experience and at the same time recognize the importance of a range of other factors for mental health promotion beyond the faith community.

This study concludes that the respondents are potential partners for working with service users, carers and service providers for the better care of people with mental illness. In terms of mental health promotion, the faith communities here represented offer several opportunities to strengthen mental health for those who belong to them.

Recommendations

- Mental health training for faith community leaders should be in the context of wider support for community development, social inclusion and health care needs for members of faith communities. Existing faith community networks should be first partners in planning and delivering training.

- Evidence of the balanced approach taken by mainstream faith community leaders should be included in presentations to mental health professionals exploring possibilities for social support in recovery models of mental health care.
- Faith communities who are hard to reach should be approached to ascertain whether they are willing to enter dialogue over mental health issues. Those who are interested should be encouraged to do so. A follow-up survey of a much simpler nature could be sent to the non-respondents to ask at what level they might wish to discuss mental health issues.
- Faith communities who receive a large number of casual callers with mental illness should make themselves known to health and social care services for advice and support. Likewise, those who already participate in supporting, hosting and organizing support groups should be linked to services. Where there is a mental health element to their work, Community Mental Health Services should have information about their projects in order to refer where appropriate.
- Faith communities should maintain vigilance in respect to practice and authorization of deliverance ministry.
- Faith communities should recognize that there remains a tendency to patronization towards people with mental illness and learning difficulties within their congregations. Approaches to suffering in terms of passive contribution are not much better than exclusion or stigmatization. Recognition of autonomy and contribution to diversity are better approaches to inclusion, and faith communities should be encouraged to practice these.
- Service user and carer groups, as well as service providers, should be encouraged to see faith communities as resources for mental health promotion, not as extraordinary places for people with unusual needs – but in terms of being ordinary places and ordinary groups of people meeting some of the ordinary needs that people have, in their own particular way.
- Further research should attempt to link this study with connected studies led by the two other stakeholder groups, ie service users and service providers. These two groups should have the opportunity to respond to the evidence that this research project has highlighted, and to help build practice objectives for faith communities to respond to what together is considered, comprise the vital component parts of a 'user friendly' faith community.

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'I SAY A LITTLE PRAYER FOR YOU.' WHAT DO HOSPITAL PRAYERS REVEAL ABOUT PEOPLE'S PERCEPTIONS OF GOD?

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Abstract

Written hospital prayer can reveal insight into attitudes and perceptions of God especially in times of crisis. Although numerous articles have appeared in the last 20 years or so recounting the results of research into this area, this has invariably been around the clinical effectiveness of intercessory prayer. This article is the result of a study of the prayer boards/books at the chapels, prayer/quiet rooms of three of the six hospitals that make up Leeds Teaching Hospitals. The article identifies and reviews existing data, reflects on the data from Leeds in detail, comparing and contrasting this with the only other significant study in this area in Ohio in 1996.

Keywords

Prayer, Religion and health, Spirituality, God, Hospital Chapels.

Main Article

Introduction

When Aretha Franklin sang her famous 60s' hit, 'I say a little prayer for you', it's doubtful whether she ever imagined that this would become the subject of any serious research. Over the last 20 years, though, there have been numerous studies into hospital prayer but these have almost exclusively focused on proving, or disproving, beneficial clinical outcome of intercessory prayer. As interesting as this research may be, both of us felt a certain scepticism about such prayer experiments. Whilst believing the importance of further research into the correlation between religion and health, we felt that the over concentration on the clinical effectiveness of intercessory prayer rather missed the point. It seemed to reflect a misunderstanding of the purpose of prayer and, indeed, a much wider confusion of what is 'spirituality'. We would endorse what Dr Keith Meador of Duke Divinity School, who, in an article in 2005, wrote:

'a model distorts who we are in relation to God. It commodifies prayer as if we have some kind of contractual exchange with God versus a covenantal relationship that begs a response from God reaching for us....imagine that these experiments had confirmed the intercessory prayer's clinical efficacy? How big would the "God effect" – if that is how we would have viewed it – need to be, to be added to the list of recommended medical treatments? Might affluent but ill people effectively outsource prayers for their healing by paying distant people to pray, in the confidence that God

will be counting votes? And if a now-proven God were to be arm-twisted into reliably responding, would faith be required any more? In the historic Christian understanding, God is not a distant genie whom we call forth with our prayers but rather the creator and sustainer of all that is.' (Meador, 2006)

Hospital prayers

What about the prayers themselves? Do the prayers, as written down on prayer boards, prayer books, etc, tell us anything about the people who wrote them and how they perceive God, especially at a time of crisis? What sort of image of God comes through these prayers? What are people seeking when they author prayers and pin them to a prayer board or write them in a book? What and who are they asking? Do these prayers indicate anything about the belief systems of those authoring the prayers and whether these help them in a time of crisis? Does the presence of prayer boards/books in chapels and quiet rooms help people and give an avenue to vent their hopes, faith, fears and needs? If so, how can we facilitate their better use?

There are very few studies concerned with documenting and analysing the content of prayer requests written on prayer boards and prayer books in any setting. We have found only three studies which examine prayer requests within a church setting: *Listening to prayers: an analysis of prayers left in a country church in rural England*, (ap Siôn 2007); *Learning from prayer requests in a rural church: an exercise in ordinary theology* (Lewis and Burton 2007); and *God images in prayer intention books* (Schmied 2002). Within a hospital setting the only study regarding this area that we have been able to discover during the literature search phase of our own research was the 1996 Grosseohme study at The Children's Medical Center of Akron, Ohio, entitled 'Prayer Reveals Belief: Images of God from Hospital Prayers'. This study involved 63 individual prayer requests taken from a six-month period at this 253-bed paediatric hospital in the US mid-west. We shall use it for purposes of comparison later on. Our own research methodology has been largely inductive and, like Grosseohme's research, the prayers have been read for what they are in themselves and as a basis for reflection.

Spirituality and prayer

In our research and reading, though, we kept again and again coming across that old chestnut so familiar to hospital chaplains: what is spirituality? A recent search of 265 books and papers on the subject showed researchers can mean at least 15 different things by it. What it is, what it means and, perhaps more importantly, what it has been corrupted into. Although we did not want to get sidelined into this, it is so central that we at least must put on record how we understand it and what we understand we are doing when we pray and pray for others.

Whilst 'spirituality' is rather overused, 'religion', it seems to us, has almost become an embarrassing term, something not to be uttered if one wants to be taken seriously. But recently two contemporary post-modern critics, Jeremy Carrette and Richard King, went as far as actually stating that whilst they believe that religion was the 'repository of the richest examples we have of humanity's collective effort to make sense of life', Marx's famous

slogan should now read 'spirituality is the opium of the people' (Carrette and King, 2005). Spirituality devoid of any existential meaning and cut off from its roots can stray into the very meaninglessness it seeks to counter. We should especially be on our guard whenever spirituality ever becomes self-regarding and self-referential – the consumerist model, with its emphasis on making us feel better or good about ourselves, surely is.

In reflecting on the prayers we noted, as does Grosseheome, that running through many of them is the idea that people's present experience (of illness and death) does not line up with people's image of God. God is good, good is caring, so why doesn't God intervene? Why doesn't God do something to keep this from happening?

So what is our own understanding of prayer, especially of intercession? In reflecting on intercession one thing we were clear about is that intercession is not a spectator sport. Christian intercessory prayer is not standing on the sidelines of a game between God – holder of all goods – and poor suffering humanity. The Judaeo-Christian tradition assumes a response from God. The stories of faith convey a message that when God's people intercede, God listens and acts. But what does this mean? Often the images of intercessory prayer seem to convey pictures either of begging ('we are in the end all beggars' – Luther on his death bed), bargaining, purchase and exchange, bureaucratic hoop-jumping, or mini-power struggles with the Almighty. These seem to embody deeply ingrained habits of exchange that attempt to interpret the practice of intercessory prayer and fail to make sense of it – hardly surprising given the all-pervading consumerist society we live in. They seem, to us, to lack an understanding of prayer as pure gift and something that involves us '*... not about getting something from God, but about encouraging oneself to obey God, about changing self not changing God*' (Johnson, in Hauerwas and Wells, 2005), an invitation to be part of an event that is unfolding.

Prayer

Prayer is attested to in written sources as early as 5,000 years ago, and anthropologists now believe that the earliest intelligent modern humans practiced something that we would recognize today as prayer. The research, if nothing else, forced us to look again at what we mean by prayer and what we think we are doing when we pray.

We looked at some definitions and components of prayer which the reader may find helpful:

'prayer is an active effort to communicate with a deity or spirit, including a monotheist God, Saints, gods within a pantheon, or others either to offer praise, to make a request, or simply to express one's thoughts and emotions. The words of the prayer may either be a set hymn or incantation, or a spontaneous utterance in the devotees own words.'

'The great spiritual traditions offer a veritable treasure trove of devotional acts. There are morning and evening prayers, graces said over meals, and reverent physical gestures. Christians bow their heads and fold their hands. Native Americans dance. Sufis whirl. Hindus chant. Orthodox Jews sway their bodies back and forth. Quakers keep silent.' (The Online Dictionary, 2006)

Beliefs underlying prayer

- that the finite can actually communicate with the infinite
- that the infinite is interested in communicating with the finite
- that the prayer is listened to and may or may not get a response
- that prayer is intended to inculcate certain attitudes in the one who prays, rather than the other way round
- that prayer is intended to train a person to focus on the recipient through philosophy and intellectual contemplation
- that prayer is intended to enable a person to gain a direct experience of the recipient
- that prayer is intended to affect the very fabric of reality itself
- that the recipient expects or appreciates prayer

We found the image of 'prayer as encore', as used by Kelly S Johnson, particularly resonated with our own understanding of prayer:

'The prayer of the faithful is a kind of encore...the community of faith hears testimony about God's work in the past and they can't get enough of it. They call out for more, not because they think God is unwilling, but because it is their role in the divine performance, a role God has given them. The prayer is neither requisition – for the band may not want to do an encore and are not compelled to do it – nor purchase, nor begging. It's a kind of gift....Prayer, like the noise of the audience caught up in the music's energy, is simultaneously a gift to the Performer and a gift from the Performer...God has created that hunger and hope, in something like the way the band moves the crowd to want more. God gives God's people the role of calling for what God intends to give.' (Johnson, in Hauerwas and Wells, 2005)

The prayer board research at Leeds Teaching Hospitals – An inductive approach

In the film *Bruce Almighty* (2003), the hero of the film, Bruce (Jim Carrey), who gets to swap roles with God for a week, attempts to file the prayer requests that his brain is being bombarded with, by putting them into the form of 'post-it' notes. He is completely overwhelmed and every inch of his apartment is covered.

Our inductive approach to the prayer slips first involved reading all the prayers carefully through. Sister Mary and I felt just a little like Bruce reading through and digesting the 952 slips from the prayer boards/books from three of our hospitals. Reading through these prayer slips we felt both moved and overwhelmed by people's honesty and sheer need. How on earth were we going to categorize these prayers? Grosseohme's experience of reading through and analysing these prayer requests certainly reflected our own here.

'There is a certain archaeological quality to delving into this body of prayer as recorded in the chapel. The prayers left behind reveal a view of God in whom the writers believe, but they also raise questions about God and God's actions. The

prayers reveal the brokenness of creation in a variety of forms and the desire and belief that God's presence and mere entry into the human situation can bring wholeness'. (Grosseohme 1996)

We need to emphasize that the research we have done is from a Christian perspective. We are well aware that those who have authored the prayers are not solely from a Christian background, if indeed from any faith background. It is simply that we do not feel qualified to be able to broaden the scope of this research beyond the parameters of our own faith community in a way that would truly reflect the experience of other faith communities.

The hospitals and prayer boards/books

Leeds Teaching Hospitals NHS Trust is one of the largest teaching hospitals in Europe with over 3000 beds and 16,000 staff. It serves the city and suburbs of Leeds with a population of 715,000 people, in addition to being a regional centre providing a wide range of specialties. In the last UK census the faith make-up of the city of Leeds was broadly shown to be 69% Christian, 3% Muslim, 1% Jewish, 1% Sikh, 0.5% Hindu and 0.2% Buddhist whilst just over 8% did not answer this question and nearly 17% stated 'no religion'.

This is broadly reflected in the admissions to the trust. The trust is served by a multi-faith chaplaincy team of whole, part-time and honorary chaplains, including representatives of all the major Christian denominations, plus Muslim, Jewish and Buddhist. Leeds Teaching Hospitals comprises six hospitals of which three were selected for the purposes of this research project. Initially, we wanted to see if there was any discernable difference between the use of prayer boards and prayer books, but our research widened into what the prayers were saying about their authors' understanding and perception of God.

St James's University Hospital is a major acute hospital with a world-wide reputation situated in the east of Leeds. The hospital chapel is nearly 150 years old and one of the oldest parts of the hospital; indeed it is a Grade 2 listed building. It is not linked to the hospital, and patients, visitors and staff have to access it by going outside. There are regular daily services with the exception of Saturdays, plus Sunday services. The prayer board has been specially made and is situated at the back of the chapel. Paper, pens and drawing pins are left on a table underneath with other literature. Prayers are dated and left on display for approximately three weeks.

Cookridge Hospital is a regional oncology hospital with approximately 90 beds. There are two wards: one five day ward and one day ward. The hospital is due to close in December 2007 and will be relocated to a larger, purpose-built, oncology centre currently being constructed on the St James's site. There is no formal chapel but a prayer room/quiet room that is situated slightly off the beaten track next to the hospital cafeteria. There are no regular services but the prayer room is open 24/7. The prayer book is a simple exercise book in which patients can add prayers.

Chapel Allerton Hospital is a hospital with approximately 160 beds over eight wards. The hospital is fairly modern and is in good condition. The hospital chapel is a purpose-built 1970s' chapel with very easy access to wards. There are regular Sunday and occasional weekday services. The Sunday services are the best attended of all chaplaincy services.

There were 1331 expressions of prayer contained in 952 individual prayer requests (some prayers combine two or more expressions of prayer) in the three hospitals between March 2004 to April 2005 on the prayer board and prayer books. This may seem small in comparison to the huge number of patients passing through the Trust each year, but given that the sample is taken from only half the hospitals in the Trust, and considering that the trust complaints department receives around 1100 complaints and just over 100 letters of direct commendation per year, it is not an insignificant number. In other words, there are more written requests for prayer than there are of complaints/compliments.

There was little difference, it seemed, whether a prayer board or a prayer book was used, although the prayer book perhaps allowed people more space to express themselves and is easier to use in liturgical services.

In our inductive approach we found that as the prayers were overwhelmingly prayers of intercession/supplication, we decided to divide prayers into the following areas:

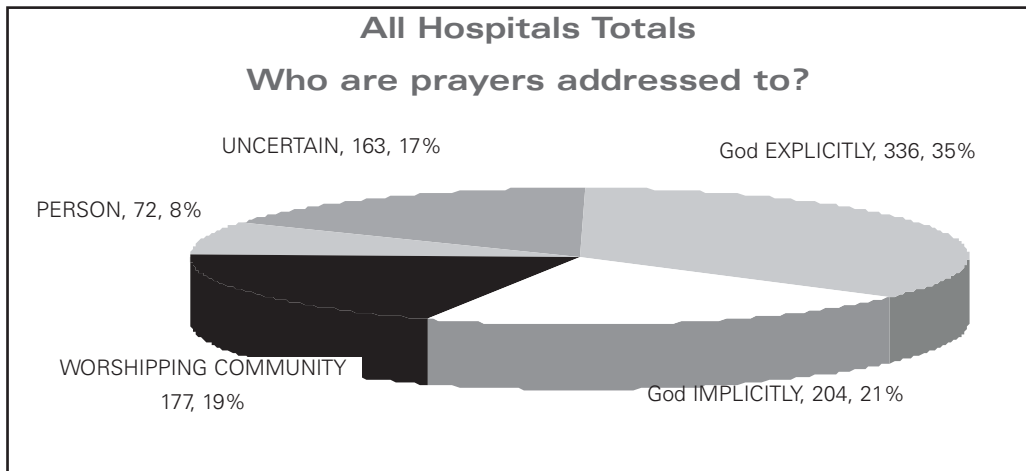
- **SPECIFIC INTENTION** - we have defined this as prayers for the sick specifically for named individuals' healing, wholeness, cure, operation, recuperation, etc.
- **GENERAL INTERCESSION** - we have defined this as prayers for the sick which are rather more general in nature.
- **DEATH** - we have defined this as prayers for people who are dying, have died, anniversary of death, the bereaved and issues around grief and loss.
- **THANKSGIVING** - we have defined this as prayers offering thanks for the recovery of patients or thanksgiving for their lives if they have died or thanksgiving for the hospital.
- **FORGIVENESS** - we have defined 'prayers asking for forgiveness' as either prayers for themselves or for people they care for, or for people trapped by resentment that they might be able to forgive others.
- **STAFF/CARERS** - we have defined this as prayers for the hospital, its staff and, very occasionally, even its chaplains.

Who is authoring the prayers?

The prayers appear to have been written by both visitors (relatives/carers), staff and by patients themselves. Sometimes this has been made obvious. Further research would need to be done in this area to determine the proportions, but as this would have to involve interviewing users this may prove to be too intrusive or even practical. Our *perception* is that the majority of the prayers are authored predominately by people from the Christian tradition or with some Christian background but not necessarily church attendees, although God is addressed in terms that make it clear that 1% of the authors are Muslims.

Who are people praying to?

The majority of the prayers, nearly two thirds, are directed implicitly or explicitly towards God. Sometimes the prayers seem to be directed towards the patient themselves or even a deceased relative or friend. The prayers often specifically mention God or variations thereof. Sometimes this is just implicit ('Thou' or 'You'). The implication is that the prayers will be read by others, certainly by the chaplains, and that people will be remembered in the prayers/service that take place in the chapel. There are a number of referrals to the chaplaincy, and even one complaint.



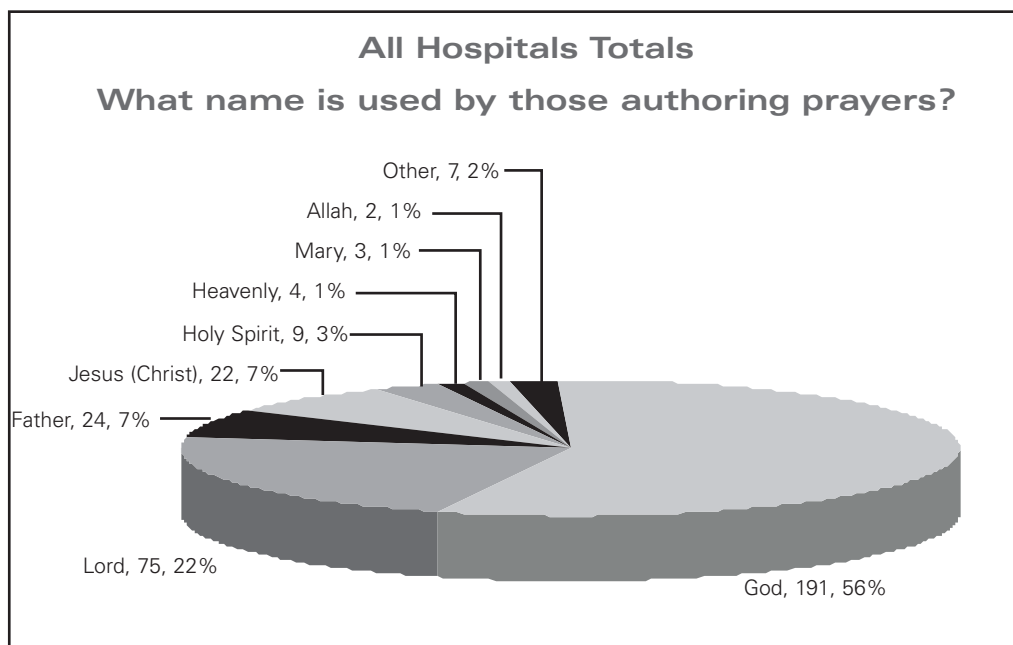
- **GOD EXPLICIT:** prayers using the word God, Lord, Almighty, Father, etc: e.g. 'Lord watch over her and help her through this crisis'.
- **GOD IMPLICIT:** prayers not using God, Lord, Almighty, Father, etc but phrases such as: 'Thou' or 'You' e.g. 'Please help me and keep me safe'.
- **WORSHIPPING COMMUNITY:** Where prayers of congregation/chaplaincy/church are asked: e.g. 'Please remember X in your prayers/ at your services'.
- **PERSON:** Directed to person or persons: e.g. 'Love you sweetheart – think of you everyday'.
- **UNCERTAIN:** Who addressed to is unknown. Either name only: e.g. 'Mark' or 'x who recently lost her mum'. Could be addressed to God, implicitly or explicitly or neither.

Worshipping community

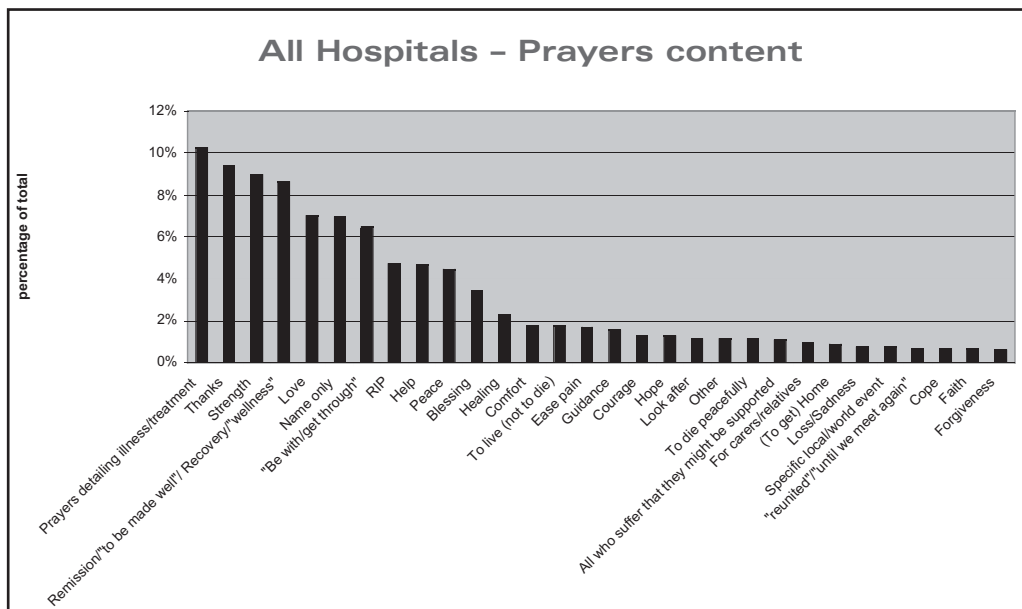
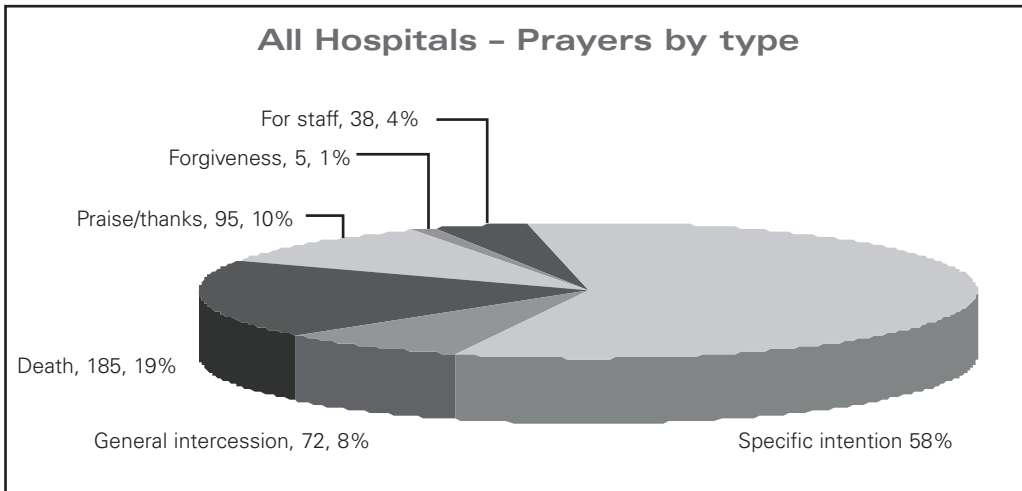
Behind the prayers lay quite a strong assumption that there is some sort of worshipping community or congregation around or connected to the hospital chapel or prayer room, who will be reading the prayer requests and focusing on those requests during services and prayer times. The phrases 'please remember at your services', 'please remember x during your prayers', 'remember x at your prayers' and variations thereof are to be found many times – 18% of the prayers were addressed to this worshipping community. During times of great stress, and hospitalization is one of the most stressful, our barriers are lowered and we share things with others that we would never normally even entertain.

Whilst it is obvious in a faith community, such as a church/mosque/synagogue, that this is a worshipping community, it is a lot less obvious in a hospital chapel (and even less obvious still in a prayer/quiet room.) The worshipping community here may be a creation in the mind of those authoring prayers but we would say a positive one. It assumes that services and prayers are regularly being held there, that chaplains and others meet for collective or solitary prayer and that people and their plight are remembered during these times. We think this demonstrates the importance of regular patterns of prayer and worship taking place in chapels and prayer rooms even if the worshipping community is very small.

What do people call God?



What are people praying for?



Comparison between Leeds hospital sites

There were some variations between sites. Whether these differences are due to the different nature of the hospitals would be speculative and would need further investigation.

It might reasonably be expected that the more traditional the chapel or prayer/ quiet room, the more God would be referred to explicitly. The data, in fact, indicates the opposite. This was also noted in relation to prayers to the worshipping community and in prayers addressed to 'person' where, again, there is a reverse of what might have been expected.

In the contents of the prayers we noted that whereas prayers detailing illness/treatment formed 14% of all prayers at St James's, this was only 7% at Cookridge and 2% at Chapel Allerton. Also we noticed that where 12% of prayers at St James's contained only a name, this was true of less than 2% at Cookridge and 4% at Chapel Allerton. Prayers asking for 'blessing', 'courage' and 'healing' were the second, fifth and sixth highest at Chapel Allerton (17%, 9% and 8%, respectively), much higher than in the other two hospitals. Direct healing was something that was the primary focus of only 2% of prayers at St James's and Cookridge but 6% at Chapel Allerton. Prayers asking God 'to be with' featured in 10% of all prayers at Cookridge but only 4% of prayers at St James's, and did not feature at all at Chapel Allerton. To 'ease pain' or 'to be out of pain' concerned 4% of all prayers at Cookridge but did not appear at all in the other two hospitals. Prayers for the repose of those who have died formed 7% of prayers at St James's, 4% at Chapel Allerton and 2% at Cookridge. Interestingly, thanksgiving formed 23% of prayers at Chapel Allerton, far ahead of St James's at 8% and Cookridge at 10%. All other subjects for prayer were roughly in similar proportions.

Comparison with 1996 Akron, Ohio, study

It might have been expected that there would be significant differences in the data between our own research and that of Akron, Ohio in 1996. With a couple of exceptions the differences are slight. Whereas 66% of people in the Akron research expressed their prayers explicitly or implicitly to God, this was 57% in Leeds. One might have expected a greater difference between Leeds, with an average church attendance of less than 10%, and Akron, the birthplace of the '12-step program', with well in excess of 50%. Similarly, prayers addressed to the worshipping community were again broadly similar with 24% to 18%. However, 11% of the prayers in Akron were addressed to Jesus directly compared to just 2% in Leeds. The people of Ohio seemed to pray more for direct healing on 10% compared to just 2% in Leeds. The people of Yorkshire seem to have only a slightly greater need to fill God in on the details of what was happening to them or their loved ones than their counterparts in Ohio – 8% compared to 11%. However, they are rather less prone to giving thanks than their American cousins – 13% compared to 4%. Although there were no references to the Holy Spirit in the Akron study at all, he/she did manage to register a modest 3% of all prayers in the Leeds study. There was no mention of any anger directed towards God in the Akron study although a very few prayers (5) in the Leeds study expressed direct anger towards God.

Images of God

The image of God that comes quite strongly through the prayers is one of a caring, benevolent, if, at times, rather distant God. God is overwhelmingly, if not exclusively, addressed in masculine terms to whom people sometimes feel puzzlement and incomprehension over what is happening to them. People expressed their helplessness at what is happening to them, for situations over which they have no control or even any understanding.

Is the image of a good, caring God at odds with the reality they are experiencing? Maybe, but overall people seemed remarkably accepting of what was happening in their lives, often asking only for strength, courage, hope, guidance, love, or whatever, to be able to deal with whatever they were having to face. Those authoring prayers seemed to feel free to express themselves in their own way. There did not feel to be any self-censorship by those authoring prayers. They did not seem to feel any need to stand to 'spiritual attention', because a chaplain might be reading their prayers. Many of the prayers expressed things that might not seem at all orthodox by any religious traditions. Prayers seemingly addressed to people, often deceased people, would be an example.

Conclusion

As has already been noted, the differences between the Akron, Ohio, research and our own in Leeds showed certain differences but on the whole were broadly similar, especially given the cultural differences between the American Midwest, the North of England and a ten-year gap. As with the Akron study there seems to be acceptance that human experience is not whole; that the experience of suffering and brokenness is so universal it is part of what it means to be human. This acceptance, though, had its limits in the Leeds study. People authoring prayers did not hold back from questioning God, expressing doubts and, very occasionally, directing anger towards God. In both studies there is an acknowledgement of our helplessness in the face of suffering and death, that we all have unmet needs that only God can meet; that however awful things are there seems to be a general acceptance that this is how things are and that God is there, somewhere.

There is an assumption behind the prayer requests that there is some sort of worshipping community connected with the chapel or prayer/quiet room and that this worshipping community, although largely invisible to the authors of the prayers, is somehow there for them. It means ensuring that we properly maintain prayer boards or books, keep them up to date and in good condition (not leaving old prayers on view from six months ago, for instance) and make a real effort to use people's prayer requests in our services and private prayers. On a practical level this means that a named person within any chaplaincy has the responsibility for ensuring that prayer boards/books are well maintained and kept up to date and used in liturgical and private prayer. There seemed little difference in content between prayer boards and books, only that the latter perhaps allowed people more space and are easier to use in liturgical services.

The fact that so many people use this facility, particularly when it is not always easily accessible and available, is significant. The open and honest way people use these prayer boards/books indicates that they find it a valuable opportunity to express themselves in times of crisis, perhaps in ways that they might not feel able to do directly with a health care chaplain or volunteer. It may be of interest for future research to look more at prayers said with people by members of the chaplaincy team as against prayers on hospital prayer boards/books. As has been noted, the prayers reveal a view of God in whom the writers believe and raise questions about. Further research needs to be

undertaken into how we, as healthcare chaplains, can better help people explore and express this more innovatively and freely.

'I pray because I'm desperate. I pray because I'm helpless. I pray all the while feeling like this. And when I do, something changes – praying changes me, it does not change God.' C S Lewis – Shadowlands

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LOOKING IN FROM OUTSIDE: CHRISTIAN REFLECTIONS ON GOD'S ACTIVITY IN HOSPITAL CHAPLAINCY

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Abstract

Following a 200-hour placement with the Christian chaplaincy team in an acute hospital, I offer the following observations from the perspective of Christian ministry. This study represents the analysis of fieldwork, which included bedside visiting, regular reflection with the team, chapel worship and the occasional offices of baptism, marriage and funerals. This was backed up by review of the extant literature on hospital chaplaincy. Chaplains were found to be operating in a highly challenging environment where their status is ambiguous and their relevance questioned. A high degree of flexibility is required of them as they traverse hourly from hospital management to ministering to health crises. In addition to general care during health crises, the distinctively Christian features which other professionals were not observed to exhibit were sacramental ministry (in the broadest sense), prophetic challenge and reconciliation. These features, in addition to general care and ministry, were unique to chaplains. In contrast to other healthcare professionals, they held a wider perspective of the patients' situation and context. Chaplains were found to be promoters of realistic acceptance in crises and witnesses to the creative power of a suffering God.

Main Article

The ambiguous status of healthcare chaplains

The climate of financial crisis in the NHS arising from pay revision, GP contracts and rising costs, is sharpened by the government's determination to retrieve the NHS from budget deficit in the short term. The trust where the current study was undertaken is forced to save one million pounds per month, redundancies are commonplace and the climate for staff is highly uncertain. Chaplains are facing the same uncertainties as all other staff, but are nonetheless still called to minister to these staff and play a prophetic advocacy role. They are called to observe by being insiders, to comment on and challenge the structures of the healthcare profession by being outsiders. DH guidance recognizes chaplaincy as an integral part of healthcare, yet a strict application of the Data Protection Act would leave chaplains requiring patient consent before patient data could be passed to them (Cobb, 2005, 113-5). Whilst rarely applied in this way, it is an illustration of the ambiguity with which NHS structures treats chaplains. Line management structures compound this ambiguous status: the senior chaplain in the current study is line-managed by the director of nursing, but also has direct access to the chief executive and is on the Trust senior management team. He is a lay member (not a 'professional')

member) of the research ethics and clinical ethics committees, despite holding the responsibilities of a senior professional within the Trust in other respects. Christian chaplains are employed by a secular institution but work within the framework of a faith tradition and are answerable to God and God's church, often with strong links into the life of the local parish and diocese. A robust sense of vocation is required to counter the ambiguous status afforded to chaplains in NHS institutions.

Socio-cultural context

We live in a society in which pain and suffering are silenced from mainstream discourse (Scarry 1985, Kleinman 1988). A minority of secular medics and psychologists challenge the mainstream, calling for a recognition that suffering is a ubiquitous part of the human condition (Kleinman 1988, Hayes *et al* 1999, McCracken 2005), whilst cultural commentators have argued that pain and illness have much to teach us and deserve more attention than they are accorded in the West (Morris 1991, Kleinman 1988). Death and dying are similarly far removed from everyday experience. In the UK, 83% of people die of non-communicable diseases (WHO 2004) as opposed to suddenly from accident or contagious epidemics. Only 20% of people die in a setting other than healthcare or residential home (ONS 2003). Dying is no longer a natural or integral part of community existence but is, in the majority of cases managed, or 'brokered' among professionals (Timmermans 2005). Healthcare chaplains are ministering in a context where suffering often comes as a shock, an assault on individuals' sense of identity in a world where modern medicine is supposed to have given us the right to not suffer.

So healthcare chaplains face a combination of attacks on their professional identity – on the one hand from those who do not understand their relevance now that medicine is seen to have more answers to suffering than God, and on the other from those seeking to trim hospital Trust budgets by targeting those who cannot demonstrate clinical efficacy and cost-effectiveness.

Healthcare chaplaincy literature: a brief review

Responses from within the community of healthcare chaplains to their role ambiguity have been varied. Swift (2004) argues in favour of theological re-engagement in defiance of pressures to conform to the rest of the system. Drawing on Foucaultian discourse, he argues chaplains need a common 'faith archive' to counter claims to truth made implicitly by healthcare managers. Others argue that modernization of chaplaincy and the drive towards evidence-based practice is an opportunity rather than a threat (Folland 2006, Gray 2003). I observed a mixture of the best of both of these attitudes, working with a chaplaincy team deeply committed to Christian faith traditions but also placing great importance on professionalism and positive co-working within the system.

The College of Healthcare Chaplains devoted all of its 2002 conference to the subject of identity in an attempt to clarify what it is they offer to today's healthcare system. They defined themselves as pastoral practitioners, promoting patient-centred care and supporting spiritual adjustment to illness (Fraser 2002), as a Godly presence and witness

in a secular environment (Mullally 2002), as bilingual translators interpreting between the discourse of professional services and theological language of faith (Hanrath 2002). Other chaplains define themselves as liberation theologians challenging the socio-political context of illness (Pattison 1997), as promoters of patient values in healthcare practice (Pattison 2000), as defenders of the uniqueness of each individual in an impersonal environment (Cressey *et al* 2000), as professionals who move beyond psychological care to bring peace with God (Lyll 2001, Cobb 2005). It is hard to imagine other uni-professions such as psychologists or occupational therapists expending such energy on defining themselves and their role. Nonetheless consensus exists that chaplains play a powerful counter-cultural role challenging a purely physical or mechanistic perspective of health and illness.

A small amount of empirical work exists concerning the value of chaplaincy as perceived by patients (Finlay *et al* 2000, Mowat *et al* 2005). Qualities valued by patients included availability, non-judgementalism, humour, confidentiality, openness to philosophical and theological conversation, the inclusion of family members in care and the offer of prayer and hope. These studies offer privileged insight into the chaplain-patient relationship, but do not focus in a significant way on the wider context of chaplaincy work.

Aims and methodology

The aim of the current study is to explore empirically the work of healthcare chaplains within the cultural context of the healthcare system, and to reflect on how chaplaincy teams channel God's kingdom values for the benefit of all in the healthcare setting. The methodology involved close observation of the chaplaincy team and my own part in that. Detailed field notes were taken and these were later coded and analysed thematically in an attempt to glean insights into where God is at work in acute care and how chaplains may shed light on this in a way other healthcare professionals might not.

Findings

Very often the work of the chaplain involves ministry to those who, although physically ill, are spiritually in good health. Elderly dying patients with severe dementia respond with remarkable grace and clarity to either familiar or extemporaneous prayer, those fearful of forthcoming treatment are greatly comforted by a visit to the chapel service or the administration of bedside communion. Both Christians and those who do not share Christian faith are relieved by good listening and wise insight. It was a delight to be part of a team ministering to people throughout the life cycle, where birth and death are daily occurrences and no issue is too big or too small to elicit spiritual care. It is frequently clear that God is working through his body, the church, to minister unhindered to those in need.

Additionally, however, and seemingly unique to chaplains, was the desire to discern God's activity and work with this in complex, conflict-ridden situations where there exists a distressing rift between people or between God and people, and where healing is needed on a spiritual level. To this end I present three themes emerging from my

analysis: the chaplain as sacramental minister; the chaplain as prophetic presence; and the chaplain as instrument of reconciliation.

Chaplain as sacramental minister

The relevance and necessity of the sacraments strikes one in a new way when confronted with health crises. A recurring theme became the intense practicality with which the chaplains used the sacraments to minister when faced with unresolved issues.

A man in his fifties with a recent diagnosis of extensive secondary tumours and a prognosis of 3 – 6 months asked to see the chaplain. He told us he wanted to get married as soon as possible to his partner of over 30 years; he wanted a simple service in the hospital. He presented anxiously, and showed no interest in knowing the details such as cost and procedure. After obtaining some details from the medical staff, the chaplain decided to offer a civil service later that week. I enquired as to why so soon, and why not a chapel service. He explained that the patient was starting radiotherapy that day; by the weekend he would be nauseous and losing his hair. By the time he felt better, there was a possibility of his brain metastases affecting his cognition. Given that the legality of marriage depends upon both parties' competence to make marriage vows, it was essential to act during the current window whilst he was well enough to enjoy the day. The time scale of obtaining an Archbishop's licence for an emergency chapel wedding would be too unpredictable. Following a few phone calls and a brief chat with a medic to sign the necessary pro forma, we were able to return to the patient and inform him that the wedding could take place four days hence. There was palpable relief on his face at the news. The insertion of this sacrament into his week, one otherwise filled with shocking news and unpleasant treatment, gave him excitement and hope.

Sacraments are communal, relational activities, and the patient's partner reacted very differently to the news of the immanent wedding:

'She looked shocked and upset. I think she has not taken in how very ill he is. We were like the angels of death coming to administer the last rights.'

(Field notes 15 May, 2006)

The chaplain was mindful of this and spoke to her later to explain the need to give the patient something to help him through the next weeks. On the day, in the day room of the cancer ward, both were radiant like any bride and groom, and I noted what opportunity for celebration and happy memory-building was created for this family through the sacrament of marriage. A subsequent visit confirmed the shift from anxiety to acceptance that had been achieved through 'putting right something that should have been done long ago' (The patient).

All parents experiencing late pregnancy loss or perinatal death are seen by the chaplain. Often this entails no more than explanation of practicalities, but naming and blessing rituals have risen from 20% in 2000, when the current senior chaplain was appointed, to 84% in 2005 (Conversation with supervisor 20 April, 2006). Although this is not strictly a sacrament, it plays a role which can be seen as quasi-sacramental: the physical

embracing of the (often greatly disfigured) dead child by someone seen to represent God offers to the family a tangible sign of God's love and acceptance, whilst giving a sign, too, of how the raw emotions of the family can be offered to and received by God. This brings huge spiritual and psychological healing to families who may feel their child is unacceptable, or somehow outside of God's love because of their imperfections.

Emergency baptism of dying babies also offers the possibility of placing unbearable grief into the context of God's love. A young couple from a socially deprived area and known to many social care agencies, gave birth to a daughter whose condition was not compatible with life. Although some disabilities had been detected earlier, the extent of her ill health was a shock when she was born. The baptism took place within the neo-natal intensive care unit, with the baby in an incubator, and gave the parents the knowledge of how many people cared for them and their situation. The chaplain adapted the liturgy so that the parents were reminded of their faith, rather than being asked to make the usual baptismal commitments, as a way of acknowledging the reality and tragedy of the situation for the parents whilst offering due respect and sacramental blessing to the child. On a subsequent visit I noted how appreciative of the support and prayers the young mother was, how unafraid of her own crushing feelings of impending grief she was and how she seemed to be 'remarkably robust in a way' (Field notes 9 June, 2006). In preparation for the funeral, the mother was calm: 'everyone is treating me with such respect', she said, 'I have never had that before.' (Field notes 26, June, 2006).

The context of human frailty and urgency in which these sacramental acts took place led to a loosening of liturgical form. The structure and poetry were retained, but more appropriate or accessible forms of words were used. Our post-modern context no longer permits assumptions that all will be comforted by the familiarity of traditional liturgy, so more natural speech forms must be used to present these ancient offices.

Time constraints, too, may force the adoption of extemporary versions of liturgy. On one occasion we ran at speed from a meeting to an ambulance at the hospital entrance in order that a Roman Catholic patient receive a final anointing with oil before he died. 'I hope I got the bit about Mary and the angels in the right place!' confided the chaplain to me on the way back to the chapel afterwards (Field notes 5 May, 2006). Chaplains do not sit praying in the chapel awaiting urgent calls. The NHS context forces them to be playing an active role in other aspects of hospital management. They may have to run from board room to life-and-death incidents in seconds. The necessary tools must be internalized and readily produced to fit each unfolding crisis. This is achieved by making prayer and reflection a key part of the working day, despite pressure to reach targets and perform efficiently. Prayer times most often occur in the early mornings and late evenings, outside of the working day as 'prayer is not an activity that sits easily within the framework of the hospital management structure' (Conversation with supervisor 17 July, 2006).

Where life is fragile and the physical and political environment not conducive, the ancient sacramental elements and human touch transcend demure ecclesiology and

point again to the gritty words of Jesus in the hostile context of his own day: 'Is it lawful to do good or to do harm on the Sabbath, to save life or to kill?' (Mark 3: 4). Chaplains must take the rich traditions of the church and use them creatively for healing, as the mess and suffering of contemporary human life demands.

Chaplain as prophetic presence

Good spiritual care is not all about good listening. In complex cases, the patient's best interests are not served by taking their words at face-value, but rather by retaining a soteriological perspective, enabling a combination of compassion and prophetic challenge. Observation of ward behaviour made it clear how powerless long-term patients come to feel. No matter how many healthcare professionals come and go, they, not the patient, control when and for how long they visit, and determine what care the patient receives. Whilst overstretched healthcare professionals struggle to maintain a busy schedule, raising their eyebrows in exasperation at 'difficult' patients, the chaplaincy team are called to see the patient in his or her entire context, including the spiritual dimension. This is made possible by regular debriefing and reflecting theologically on challenging encounters. Chaplains reflect on one another's impressions of patients in order to build up a whole picture and remain compassionate. I reflected after one team meeting where my difficulty in ministering to a particularly complex patient was discussed:

'It's such a relief to find [team members] are so honest. It would be awful if they needed to be "nice" all the time and to listen endlessly to all the deliberately confusing tales and complaints. It's as if [patient] is saying "I will wear you out before you help me!" [...]. [Patient] wants to draw you in without letting you help. I felt an urge to get her out, to make her move, to say, "take up your bed and walk!" [...] I feel no hope at being able to help her, but determined not to let her distress win by giving up...'

(Field notes 28 April, 2006)

In such instances, chaplains may visit in twos to learn from one another's practice, often with one observing and listening to God whilst the other engages with the patient. I noted how God works through clear and authoritative leading from the chaplain:

'[Supervisor] stays at the end of [patient's] bed and insists on being heard and uses firm body language to take control. [...] If [patient] is ever allowed to take charge of the conversation, she goes on and on and on to no great end and in fact in a way that confuses herself and exasperates those around her.'

(Field notes 30 April, 2006)

At the end of that visit the patient brought up something of genuine concern for her, requesting advice on how to improve a family dynamic. On another occasion, this patient reflected that the chaplain always came back the next day whenever she (the patient) became angry. She knew she was accepted in her fullness and could not drive the team away. I was struck by the power of clear compassion and how it interrupted the behaviour that repelled those around the patient. Here chaplains act as channels of God's values by offering empowerment, acceptance and unconditional love. The priestly

authority which insists on communicating within a framework of reality and integrity was not always forthcoming from other professionals within this busy, under-resourced setting. I was more than once ironically wished 'good luck' by staff at ward nursing stations before visiting patients exhibiting challenging behaviour.

Chaplains often transcended the boundaries of normal conversation, insisting individuals talk candidly about hard matters: patients may have to go to a nursing home instead of back home; bereaved relatives must face their grief instead of going into denial; angry relatives must hear that the patients' notes are accurate and no one has been lying to cover anything up; manipulative patients must understand they cannot control their future by refusing to comply with treatment; consultants may need challenge regarding complex care needs. A combination of surprise and recognition emerges on the face of the recipient in light of such honest challenge from the chaplains. Our post-Christendom context no longer allows chaplains to assume the respect of those they minister to. Like Amos or Jeremiah in their day, they must speak the truth as they see it and not be driven by a need for comfortable relations.

At times the prophet's role involves obediently witnessing to God's presence even when it feels impotent. Following the death of a young patient from largely self-inflicted causes, I reflected on what I was doing there:

'I walked from the mortuary to the car. I don't like to think of [deceased patient] in a refrigerated filing cabinet with a name label on the outside. [...] What is God doing when those who are least able to benefit from any help and support we offer are the very ones who most get under our skin? – the ones who tire us and demand our very best thinking are those who, by the very nature of their need, cannot receive or understand what is on offer...'

(Field notes 11 June, 2006)

God's heart is to seek and retrieve those who are furthest from him (Hosea 3:1, Luke 15) and it is not ours to sulk at God when we do not get what we wanted (Job 42: 1-5, John 4), but to keep on offering our best and seeking God's purposes even though 'success' is not forthcoming.

Chaplain as reconciler

The crises of illness and dying can give the chaplain opportunities to work towards reconciliation between family members. It took me some time to understand that this is what God was doing. Close to the death of a young patient with a long and complex history of physical and psychological illness, I spent time alone with her talking and praying, and also with her family around her bedside as she slipped in and out of consciousness towards death. I found myself keeping a prayer vigil for her during those last days of her life and had to acknowledge some confusion as to what my roles were. What was the 'outcome' I was seeking to achieve? Perhaps it was me more than her who needed God's reassurance at this time? Her behaviour whilst more physically well, had fluctuated between open acceptance of Christian faith and a complete refusal to

communicate with anyone, least of all the chaplaincy team. But during her last days she did show signs by eye movements of appreciating the presence of the team and consented to a final anointing. I was reminded of the need to not confuse people's reaction towards those representing God with their actual inner faith in God. It was essential to trust God and not to get in the way of God's ministry. The very day the patient finally died, I read:

'In the early days of ministry it is possible to become quite messianic, believing that the presence of God in a situation depends on our being there. Instead we should offer such pastoral ministry as seems appropriate, and then get out of the way, making room for the spirit – and giving the family space to be with one another.'
(Lyll 2001: 104)

I later discovered that this was the first time this family had been able to be in one room together without warring for many years. In the presence of tragedy, God's spirit quietly lifted the veil of human distress and the illusion of being right to allow peace to reign and death to be dignified. The involvement of the chaplaincy team was not for the purpose of producing some wise gem at the 'right' moment, but just to provide a holding of the space, so the patient could be reminded of God's love, the family could feel safe and God could minister in God's timing.

The death of an infant a few weeks later provided similar opportunities for reconciliation among members of a socially vulnerable and geographically dispersed family. The respect offered by the chaplaincy team enabled the expression of emotion by providing a safe space to cry or shout, so that potentially destructive feelings were not vented in damaging ways.

Like Isaac and Ishmael at the death of Abraham (Gen 25: 9), Jacob and Esau at the death of Isaac (Gen 35: 29) and Jacob's sons at his death (Gen 49: 1-31), family members supporting one another and the dying relative seem to fulfil a deep-seated longing in humans for death to be a time of reconciliation, mirroring the death of Jesus whose death reconciled all things to God and foreshadowing our own ultimate reconciliation with God after death (2 Cor 5 18).

Discussion

The work of the chaplain is to promote spiritual health, in all its dimensions, in a context of physical ill health. Spiritual pain is sometimes understood as something which draws us towards God. When, by God's grace through maturity of faith, the pain of mortality and suffering are willingly accepted, it is the greatest privilege of a chaplain to hold the hand of the patient in solidarity with their sufferings. This is the kind of spiritual pain described by Ignatius of Loyola or John of the Cross; it is a 'sharing in the growing pains of the created world' (Burton 2004). When there is something interrupting this communion, however, it is the job of the chaplain to see into the patient's world, to discern how to reduce futile struggling, and to promote realistic acceptance and reconciliation. Patients in a health crisis are helped by realizing they are in transition, that

there is no going back, but that they may nonetheless look forward with acceptance to a meaningful existence (Williams 2001, Wells 2001, Hanrath 2002, McCracken 2005). Beyond the popular psychiatric model of promoting good coping, 'there has to be some possibility of finding creativity and hope in the midst of despair, tragedy and destructive loss' (Ballard 2005). Pain and death are not anodyne, and a Christian chaplain must remember that Jesus wept and sweat blood at the prospect of the suffering before him in a way that Socrates did not (White 2005). Our faith in the creative and re-creative powers of God elicits awe and fear, because Christianity is an embodied faith, not a dualistic one. Not the promise of fluffy clouds and a free-floating disembodied soul, but the grit of blood, sweat, tears and messy emotions must be the raw material the chaplain offers to God. It is the vulnerable, disfigured and suffering God (Moltmann 1974, Buxton 2001) we take to patients. The senior chaplain at his interview for the post declared that he does not believe in a God who sits by the patients bedside or holds their hand, or who demands theological explanations for pain and suffering; he believes rather in a God who vomits into the sick bowl with the patient and who winces in the agony of serious illness (Field notes 17 March, 2006). Chaplaincy is about seeing God in the patients and finding ways of making God's presence tangible to them through the sacraments, through facilitating reconciliation and through speaking of God who is both within and beyond all our reality.

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PUTTING A TOE INTO THE WATERS OF RESEARCH – A PALLIATIVE CARE CHAPLAIN'S PERSPECTIVE

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Abstract

Opportunities to undertake research from a chaplaincy perspective, in areas of religious and spiritual care, are often desired but may be frequently thwarted. The demands of a diverse and sometimes disjointed work practice, a perceived culture ill at ease with a research mind set and an uncertainty on how chaplaincy may embark into this different world may impact against such ventures. However, research increasingly has been chaplaincy led in many quarters and its importance and value has been well documented (Speck 2005).

In this article, the author shares his initially tentative journey into the milieu of research and the opportunities to initiate and be involved in three distinct research studies. While he shares some of these results, the focus on the article is primarily on the process of exploring and engaging in research. The author finally advocates for an increased emphasis on interdisciplinary research and proffers those factors present that underpinned and facilitated his interaction with research.

Main Article

The Research Laboratory

Princess Margaret Hospital (PMH) was the base for this research and is located in downtown Toronto. The hospital has a leading international role and reputation for the provision of comprehensive oncology care in North America. PMH is also a teaching hospital of the University of Toronto and a research centre of world renown. The specific venue for the three studies was the Palliative Care Unit, which was purpose built and opened in 2002. It is a 12-bed acute unit, with primary focus on both symptom management and terminal care. The average length of stay is 12 days and 50% of patients die on the unit. With an emphasis upon addressing patient symptoms, 24% of patients are discharged home and the remaining 26% are discharged to longer-term palliative care units.

There is a strong dedication to providing appropriate and holistic care to the diverse population that avails of the services of the unit. It would be unusual among the in-patient population not to have at least four of the major world faiths, and those of none, represented at any one time. Such a multiplicity requires sensitivity, on the part of all staff members, to meet the religious and spiritual needs of those within their care. This

commitment is made manifest, with the provision of a 0.5 Whole Time Equivalent (WTE) chaplain dedicated specifically to the unit. In addition there is a 0.5WTE dedicated social worker and both professions were fully integrated members of the interdisciplinary team and were expected both to chart their professional assessments and patient interventions and also to contribute at the weekly rounds. In addition to the provision of a 0.5WTE chaplaincy post, pastoral ministry was also provided by pastoral visitors who were departmentally trained and received ongoing supervision. In addition, there was a core group of specific faith endorsed representatives who provide appropriate religious care on request. Consent was a pre-requisite to any chaplaincy services involvement.

In the face of many deaths on the PCU, chaplaincy initiated a monthly support time, which facilitated staff in sharing their experiences and also the impact of the many deaths on the unit. Initially, it was viewed by some staff suspiciously as a religious thing but it became an integral and appreciated part of staff support. Chaplaincy also has a role in the education of staff on the variety of religious, cultural and spiritual needs of the patient and their loved ones.

Research

There is a very strong culture of research within both Princess Margaret Hospital and its two sister hospitals that form the corporate body of University Health Network (UHN). Chaplaincy services, as this article sets out, became a partner only of late in this research culture. Two of three studies undertaken and described in this article, while initiated by chaplaincy, were multidisciplinary by nature. The first and simplest study remained within the remit of the chaplaincy department. As the studies progressed and the subject matter became more complex, palliative care physicians, a biostatistician and then, in turn, the unit social worker became partners in the research studies. This, without doubt, enhanced the depth and quality of the research undertaken. New perspectives on possible and already suggested areas of research were enhanced as the participants met and shared ideas. Present throughout the process was the generosity of the palliative care physicians who were both well-seasoned researchers in their own right. The biostatistician ensured that hunches were tested and grounded in the reality of his statistical methods.

Also present within UHN was an active Allied Healthcare Research Committee, which encouraged those professions that traditionally were not part of the research life. An annual Research Day fostered the pattern of encouragement where new researchers were supported to undertake projects that could be presented on the day, either as poster presentations or as oral presentations. Support was also made available to present research work locally, nationally or, on occasion, internationally. This was complemented by workshops as diverse as writing research proposals, sourcing funding and biostatistical methods. Such a culture assisted those who were tentative to embrace research. Encouragement was constantly offered by the then Senior Chaplain, Revd Fred Koning, who correctly believed that research would enhance the departmental profile. Concurrently, chaplaincy began to make a financial commitment, funded privately, to research as exemplified by a former CPE resident who was appointed as a short-term

researcher. This work (Van Nooten *et al* 2006) , recently published, centred upon how the evolving computer resources within ehealth could enhance the provision of chaplaincy services.

One thing of importance learned from this journey has been the centrality of operating out of an appropriate ethical framework. In the initial study the approval sought was more informal through various departmental heads rather than the later studies, which sought and received ethical approval from the hospital's Research Ethics Committee. In this area the support of well-experienced researchers proved invaluable as one negotiated both a new language and a new mind set.

Three Studies Undertaken

There was a clear and logical development in the three studies undertaken within the PCU. From the results and insights gleaned from the first study another one developed and then in turn the third study. The population chosen for the first study was the members of the interdisciplinary team, who provided direct patient care. As a first venture into research, from a chaplaincy point of view, this was seen as an appropriate group to study. On observing the commitment given by the staff to those in their care, and the associated demands of such professionalism, there was an obvious area to begin to explore. It needs to be stated that, other than Study 3, the numbers involved were small and so care must be taken with regard to any inference based upon the results.

Study 1: The Introduction and Benefits of a Spiritual Assessment Tool

An initial study, which has been published already (Pierce *et al* 2004), focused on the implementation and evaluation of a Spiritual Assessment Tool (SAT) into the life and practice of the PCU. The results clearly demonstrated the benefits of such an action, as experienced and then expressed by the staff.

The aim of this study was to determine if individual formal spiritual assessment would impact and optimize patient care. Staff members, across the multidisciplinary team, were asked to complete a confidential questionnaire regarding their understandings of spiritual/religious care. Questions addressed the frequency of spiritual needs being raised by patients, the staff comfort level in addressing such issues and the resources used by staff to address these needs. Once the questionnaire was completed, a base line position could be established prior to implementation of the SAT. While spiritual assessment was an informal part of chaplaincy practice, it now, with the support of the staff, became part of the formal chaplaincy work practice. As chaplain, I commenced to undertake a formal spiritual assessment of each patient on the unit. The tool used was the HOPE tool (Anandarajah *et al* 2001) due to its simplicity and usability across the team. In format it was a two-sided A4 sheet located centrally within the patient chart. One side comprised of pertinent patient data covering religious, sacramental, family and ancillary information. On the reverse side was the spiritual assessment. In design, clarity and accessibility were deemed prime criteria.

The survey noted that 44% of staff acknowledged that they did not always feel comfortable in patient encounters when centred upon matters religious or spiritual. Just over 50% stated that they frequently used the chaplain's written notes in the patient's chart and 61% frequently consulted the chaplain on matters religious/spiritual.

Ten weeks after the introduction of the SAT in the chart, a second survey was designed and offered again to members of the team. Questions were framed to assess the team's use, understanding and evaluation of the SAT. By this time 75 spiritual assessments had been completed by the chaplain and placed within the charts. From a patient-care perspective, 93% felt that its introduction had enhanced patient care to some extent. In terms of staff discomfort level with spiritual encounters the figure had dropped from 44% to 25%. Further results spoke of how staff now had a better understanding of the role of chaplaincy services, the language and culture of religious and spiritual care and how such needs could be addressed within a wider team. Clarity around such needs led to an increase in referrals, especially from those members of staff who were unsure of what chaplains actually did.

Study 2: Spirituality and Religion – Experiences and Resources of the Nursing Staff of a PCU

Reviewing the results of Study 1, issues became apparent as to how the staff drew from their own religious and spiritual experiences and values. Also of note was the impact such matters had upon the individual coping style and professional practice. A second study (Pierce *et al* 2005) was then designed to explore how members of the nursing team addressed the religious and spiritual domain of patient care. Study 2 reviewed how personal, religious and spiritual resources of members of the nursing team might underpin: (a) the professional practice; and (b) the personal coping mechanism of the staff. We were aware that research had established a link between the addressing of patient's spiritual and religious needs by staff and the sense of well-being of patients.

Again a questionnaire was offered to the nursing staff with an 89% return. Questions addressed demographic and career data, different understandings and definitions of spirituality, the personal resources that nursing staff drew from, their education and training in this area and, finally, their personal experience and value system of spirituality and religion. A number of interesting results were found. There was an equal split between nurses who acknowledged an affiliation to a religious grouping and those who did not. This seemed to be an interesting criterion to work into the analysis of the results.

There was near universal agreement that spirituality may be expressed in non-religious terms, with not surprisingly a greater degree of emphasis on the broadest definition of spirituality by those who did not see themselves affiliated to any religious grouping. In terms of a nurse's ability to address the spiritual domain as fully as the physical, social and emotional, 63% felt that this was achievable. No significant difference was noted between those affiliated to a religious grouping or those not. Between both groups there was also no significant difference when asked if their own personal spirituality helped them in their practice. Again this question elicited a near universal agreement.

One area where the difference between the two groups was highly marked was with regard to whom a nurse would refer a patient, who had made known their spiritual needs. Those affiliated to a religious group stated that they would only refer such patients to the chaplain. On the other hand, those with no affiliation were happy to refer to chaplaincy but also to other services as the need arose, such as psychiatry, social work, or psychology. This was quite an interesting finding and also correlated to the age profile of the nursing staff. The younger members of staff tended to be more connected to a faith tradition. Culturally, too, those who were affiliated to a religious grouping tended to be from a tradition where the male priest was seen as the sole provider and authority figure on matters religious and spiritual.

Study 3: Staff Stress and Work Satisfaction on an Acute PCU and a General Oncology Unit

Drawing from the first two studies, issues were arising around how staff cope with the various stresses of working within a palliative care unit. A third and more extensive study was then designed and undertaken. The presence of experienced researchers, such as Dr. Camilla Zimmermann, broadened the perspective of the study by suggesting we include a comparative piece with an Oncology In-patient Unit (OIU) also located within PMH. In this work the sources of staff stress, support and the coping mechanisms identified by staff on the PCU, and also on OIU, were explored. The results have been accepted for peer reviewed publication and should be in print during 2007 (Pierce *et al* 2007).

Research has established the presence of compassion fatigue among healthcare providers. Study 3 has explored the implications, both personal and professional, for staff of the PCU and OIU regarding the experiences of multiple deaths of patients. Also explored was the impact upon caring staff of having to face a diversity of dying patient situations, e.g. parents of young children, patients in spiritual, physical or emotional distress. To meet these situations, questions were addressed as to the coping mechanisms and structural resources provided within the hospital setting.

Within the PCU the average number of in-patient deaths was approximately 15 per month, rising on occasion to 25. In this study the most salient result was that the PCU staff were more likely to perceive that their work experience had positively altered their attitude to death. From a hands-on chaplaincy perspective, the introduction of a monthly staff time of reflection, which only happened in the PCU, was seen as a significant resource to address the stress of the working environment. Comparing the two units showed a greater stress level on the OIU staff when caring for dying people. A number of pertinent factors were noted. On PCU, death is a normal happening and expected rather than the sudden deaths experienced in OIU. Structurally, the PCU had more resources in the form of ethics and multidisciplinary rounds, a strong commitment to training and staff education and staff also had a greater autonomy in their work structure – a factor acknowledged as enhancing staff satisfaction.

Staff in OIU had greater stress in caring for patients in spiritual distress. It appears that the presence on the PCU, of the chaplain, whose office was located in the heart of the unit, allowed the chaplain to be seen as part of the team rather than as a consultant who appeared on request. It also appears that staff on the PCU, on identifying patients in spiritual distress, availed on chaplaincy services promptly.

Discussion

Why should chaplains engage in research? In a recent article Bay and Ivy (2006) identified four reasons why chaplaincy should embark in this direction. Firstly, they advocate that 'pastoral research' facilitates a better understanding of which interventions can enhance patient care. Secondly, that research enhances chaplains' acceptance as professional by the scientific community with whom they engage. Thirdly, they advocate that such research, albeit undertaken directly with patients, is a reminder that there is a spiritual/religious dimension to health. The final reason suggested was the presence of the opportunity and reward of being disciplined in several different areas, such as daily visits, tracking data, team development and communication.

All four are valid no doubt for the milieu from which the authors write. Correctly, they identified that individuals in the main who do such research receive no direct reward. As I reflect upon the milieu that I operated within, I am conscious of the somewhat driven North American culture, which fostered a competitive atmosphere within and beyond individual departments. As part of my year long CPE residency program at UHN, I was expected to research and publish in some area of my chaplaincy work¹. Research was viewed as one of the ways, in addition to professional care of patients, within which the status and sphere of departmental influence could be enhanced. Chaplaincy services had a high profile within UHN through its Clinical Pastoral Education Programs, which currently operate across the three sites. It is hoped that in time a Chair of Religious and Spiritual Care will be established to enhance research in this area. Such an innovative desire appears to tie well into the ethos of an organization that invests heavily in research in terms of both personnel and finance commitment.

The opportunity to undertake research and publish can be a further opportunity to show the diversity of roles that chaplains undertake within their work setting. As a former colleague reflected: 'it's good press for the smallest department in the institution'. Reflecting back, my evolving journey of chaplaincy research has shown the importance of a supportive milieu where tentative steps are encouraged and necessary resources are provided. The presence of committed and supportive colleagues, who valued the contribution of chaplaincy, and the reality of meeting all the needs of the patient was crucial. The interest in matters spiritual by the physicians on the unit was exemplified by one of their number, Dr. Dori Seccareccia, who has undertaken a Masters of Clinical Science in the area of 'Addressing the Spiritual Domain in Palliative Care'. Generosity, in terms of time and commitment, from those already mentioned, was very much the ongoing reality of this experience.

1.A research project is also an expectation of those students undertaking CPE at the Advanced Level at Kerry General Hospital, Ireland

There may be a temptation to want to keep matters religious and spiritual within the remit of the chaplaincy profession. Some chaplains may view the increasing interest of nurses and physicians into matters of spirituality with some concern. My experience has been that sharing ideas and interests beyond the world of chaplaincy has both enhanced and affirmed the position of chaplaincy within the organization. Working with members of the multidisciplinary team who had clarity around respective roles was a positive experience. One of the concerns for some in chaplaincy is that we may not have either a common language to talk to administration or a common language to engage with the scientific world. The ability to engage, albeit tentatively, in the world of statistics and scientific methods can help in this perceived distance.

In summary, the presence of the already mentioned factors provided a supportive environment for first steps in research. While such resources may rarely be present in many institutions, the possibility of developing supportive relationships with skilled colleagues can be a formative first step in the research journey.

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MENTAL HEALTH CHAPLAINCY AND THE ARTS: GROUP WORK IN A HOSPITAL AND COMMUNITY SETTING

Jonathan Baxter is lead artist and coordinator of the Sheffield Care Trust Chaplaincy Art Project (CAP)

Abstract

Following an introduction from the Senior Chaplain, the artist offers a report on a project to redecorate the chapels and multifaith spaces of the Sheffield Care Trust Chaplaincy. The report highlights the pastoral benefits to be gained from working with the arts, and includes comments from participants and suggestions as to how similar projects might be established.

Main Article

Introduction

From **Revd Harry Smart MA**, Lead Chaplain for the Lincolnshire Partnership Trust, previously Senior Chaplain for the Sheffield Care Trust (1999 – 2007)

The Sheffield Care Trust Chaplaincy Art Project (CAP) ran over the year 2006. Its intention was to decorate the multifaith chapels and Muslim prayer rooms in the Sheffield Care Trust using work done by mental health service users. The artwork would offer a way to explore the spiritual journey, which patients undergo as they work through their experience of illness, and this expression of exploration and growth would become a significant part of the worship spaces within the Trust.

One of the definitions of spirituality by the Care Trust's Spirituality Project Group has been that 'spirituality includes the journey towards meaning and purpose in life, involving self-expression, relationships and mental health'. Integral as well is 'a desire for respect and love for self, others, our environment and perhaps something beyond ourselves, a life force, God or greater purpose'. CAP created a great atmosphere in which these essential elements of life could be explored with guidance and support using the medium of art.

Mental health chaplains have the opportunity to develop groups that will involve patients for one session or over several weeks because of the longer period people spend in hospital compared with general acute care. This enabled CAP to offer some direction and encouragement in various art processes whilst also creating an atmosphere of trust and openness. People's personal stories, hopes and frustrations were shared and

this, along with the humour and enjoyment within the group, meant that the groups were often very moving. As you will see in the rest of this report, responses from participants were positive, commenting as much on the way the group worked together as on the artwork produced.

CAP received a lot of support from nursing staff, occupational therapists and others. Their support was essential in gaining permission for patients to attend the workshops. Staff sometimes participated in the groups when they were accompanying patients on one-to-ones. This created a different atmosphere from normal, but it was an important opportunity for nursing staff to work with patients in a slightly different way. It also gave staff the opportunity to explore their own artistic abilities. Although not the primary aim of CAP, it may be a valuable contribution to staff well-being to create an occasional, easily accessible art group for them, too.

Setting up and maintaining something of the scale of CAP demands time and resources. Without the support of the head of Arts and Culture within the Trust (Laura Richardson), it would not have been possible. In particular, she provided advice on sourcing materials and writing funding applications. My colleague Sally Ross was also involved in applications and participated in the first three months of the project. We were grateful also that the Director of Adult Mental Health (Pam Stirling) backed our work. All the service users and artists who participated at the sessions made it a profound and rich experience.

Making it happen

Hello, I'm in Despair!!

You know u know u really are there!!

U don't av to agree!!

Just don't please leave me!!

Not now, your presence I need!! ... ¹

The aim of CAP was to work alongside patients on six acute psychiatric wards, creating a variety of artworks to be displayed in the three multifaith chapels, the two Muslim prayer rooms and other locations within the Trust. In addition, a community project was established for former patients and other service users, who wanted to make use of the opportunities provided by CAP.

The seeds of the project were sown over a two-year period when I worked voluntarily as an artist and workshop facilitator for the chaplaincy. This meant that a good working relationship with both the chaplaincy staff and many of the patients had been established before the more formal content of the project was mapped out. Consequently, a realistic appraisal of the working environment and the ability of the patients (and staff!) was taken into account before the project commenced.

1 Quotations are taken from material written by service users who worked with the Chaplaincy Art Project. Anonymity has been respected throughout, unless otherwise requested by the artist/service user.

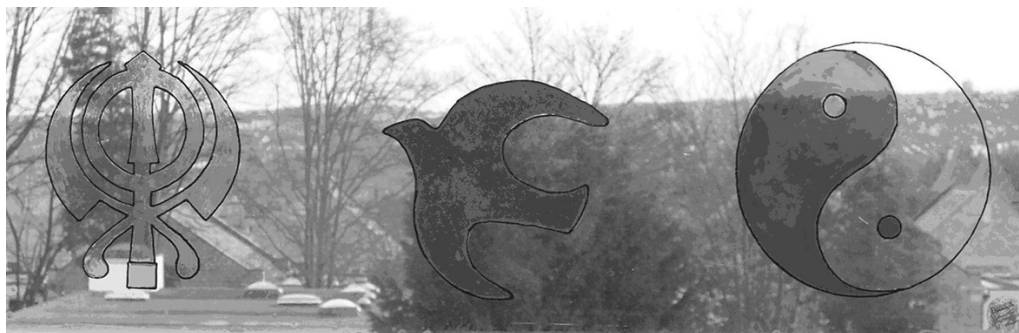


Michael Carlisle Centre Muslim prayer room. CAP installed new blinds, painted the window pillars and created a ceramic wall design based upon traditional Islamic designs.

With the support of the chaplaincy and with the addition of another artist (Sarah Gittins) and a chaplaincy volunteer (David Petts) – a service user – negotiations for the project got underway. The first hurdle was funding, but with a clear intention and a designated time period that hurdle was easily dealt with. Funds were generously allocated by the Sheffield Care Trust charitable funds, Westfield Health, Awards for All and Grants for the Arts (the latter two awards being Arts Council initiatives). In total, the funds came to £17,425 with the bulk of that income generated by the Arts Council. Expenditure for the project included the artist's wages, art materials, transportation, supervision, advertising, room hire (in the community) and, that most essential provision, fairtrade tea, coffee and biscuits! The chaplaincy also contributed income in kind.

A flying start

Despite the inevitable teething problems that accompany any new venture, CAP got off to a flying start. Two art workshops were held each week: first at the Michael Carlisle Centre (MCC), then, alternately, at the MCC and the Longley Centre, and then, at the MCC and the community project – a project that took the name, Drawing Space. Artworks which were created at the three locations included, among other things, two large mandala wall paintings, two felt wall-hangings, three mosaic tables, two Islamic ceramic wall designs, 24 cushions, a variety of photographs using different photographic techniques (such as pinhole photography), collages, drawings, paintings and prints (including silk screens), as well as poetry and prose. All of these artworks (with the exception of the photographic project) were made whilst sitting around a large table, usually with an average of eight participants, including the artist and chaplaincy representative.



Michael Carlisle multifaith chapel. The windows were designed with appropriate religious symbols, painted with glass paint on perspex, representing Hinduism, Buddhism, Judaism, Christianity, Islam, Sikhism and the Chinese faiths/philosophies. This image shows the last two symbols with an additional, linking symbol of the Spirit.

The participants ranged across a spectrum of classes, cultures and faith groups – typical of a Secondary Care Trust – some identifying as artists in their own right, but many having had little involvement with the arts, whether practically, in terms of making, or as participants of 'high culture'. This meant there was a certain risk in attending CAP, but also a surprising sense of relief, of camaraderie and often levity, as people engaged in the play of creativity in a safe, and as they saw it, informal, environment. Although the project was not promoted as a therapy, it was, nonetheless, therapeutic. One participant expressed himself as follows: 'I think the project is good because it takes you out of yourself and shows you what you can do for yourself. It's creative, relaxing, therapeutic and philosophical. You can express yourself freely and it teaches you things about yourself.'

Working on joint projects, such as the mandala paintings or the mosaic tables, was a good starting point for less confident participants. And the sense of satisfaction during the project, from seeing completed artwork put on the walls, was often palpable. Without exception, all the CAP participants went on to create their own artwork, often to be displayed in their own rooms or on the ward, or given to family members, friends, or other participants or staff. Indeed, this quality of generosity and the sharing of resources, whether through artwork, humour, empathic listening, or practical advice, was characteristic of CAP.

During the lifespan of the project CAP worked with over 200 participants, many of whom attended for the duration of their stay in hospital. In the case of the community project, Drawing Space, there was a core group of four 'members' who attended weekly for a five-month period, supplemented by 'drop-in' participants. The regularity of the attendance figures can be accounted for by the geniality of the working environment and its productivity. Indeed, by working on focused projects, with a balance between group work and individual artwork, CAP maintained a steady creativity that kept the project focused and fresh for both participants and organizers alike.

Reflections

Throughout the project participants were provided with questionnaires asking for their name, date of birth, nationality, their previous involvement with the arts, their perception of themselves as creative individuals, whether or not they identified as having a religious faith or spirituality and if or how CAP had helped them reflect on their lives and their journey towards healing. Everyone who filled in the questionnaire thought that the project had been a valuable experience.



Longley Centre multifaith chapel. Included here are a mosaic table with a river-like design, a felt wall-hanging depicting the tree of life (with prayer pockets) and an acrylic painted wall mandala (a symbol of healing and community) with a leaflike design. There are also hand-painted cushions with images that represent hope and future possibilities.

One reason for this positive feedback was due to the group dynamic: 'it was a good laugh'; 'I enjoyed it'; 'it was simple and nice'; 'it had a soothing effect on me'; 'I liked the people'; 'I liked sharing with others'; 'you all take an interest in me and talk to us nicely'; 'I feel relaxed in the atmosphere of the chapel and its informality'.

Coupled with this, participants had clearly enjoyed creating the artworks, even when they had previously not enjoyed their exposure to the arts. In answer to the question, 'Have you enjoyed doing art before?', one participant answered, 'No, absolutely never. I wouldn't be seen dead doing it.' In answer to the next question, 'Have you enjoyed the Chaplaincy Art Project? If yes, why?' she answered, 'Yes, it has been very beneficial and relaxing. I have been able to express myself freely and without embarrassment in a confidential, peaceful atmosphere.'

Other participants, with more familiarity and involvement in the arts, also benefited. One participant put it this way: 'I enjoy trying things that I have never done before and the group is a good introduction to other forms of art that I have not considered. I enjoy watching different people exhibiting different interpretations and creativity, and this often gives me new ideas too. Group activities mean that more ideas can be shared and encouraged as often I do my work alone.'

In answer to the question, 'Have you thought much about your spirituality and what gives meaning to your life and how the arts may enrich this?', the answers were both wide ranging and affirmative. One participant answered boldly: 'My spirituality is very much a part of my art as I consider my ability to enjoy art a gift, as well as a worship.' By contrast, another participant answered as follows: 'Yes, I think about it [my spirituality] all the time and this project has certainly helped give me a "lift" when needed. ... It has helped me express some feelings that I am not able to verbalise.'

Drawing Space



Here, from left to right, are Harry Smart, David Petts, Amanda Evans, and Carol Kallend, receiving their own Drawing Space publications. These publications included paintings, photography, poetry, and prose created within the group. The covers were made from silk-screen prints created by the participants.

Although CAP has now come to a close, the Drawing Space project continues. Set up as a splinter group of CAP, but offering an independent space from the Sheffield Care Trust, service users can drop in once a week to take part in a variety of art activities. While offering continuity for service users who have benefited from their involvement in the arts when resident in one of the hospitals, it also provides a community resource where people can discuss any concerns they have in a community context sympathetic to their needs. One participant commented: 'Doing these groups helped me to get all the demons

out of my system and I am now much more confident. Talking to Jonathan and Harry I have had more openings to tell my story. And I now feel more like myself.'

Conclusion: 'a 100% vast improvement'

Over all, the project, both in the hospitals and the community, has clearly been of benefit. Participants have learnt new skills, gained confidence in their own creativity and discovered that artwork, whether in practice or appreciation, can help them manage experiences of mental distress. In addition, the once dreary multifaith chapels and Muslim prayer rooms are now places of appropriate creativity; they have images and decorative furnishings that express the hopes for health and well-being of mental health service users and staff in a way that is inclusive of all faith groups and none. On the last day that the artwork was being installed in the Longley Centre multifaith chapel and Muslim prayer room, Pete Kimber, the Trust's joiner, commented: 'To be truthful, before it didn't look like anything at all. It's a 100% vast improvement now. Before, it was really dull and dismal. No colour in the place. This has really brightened it up and it looks like something. It really works well.'

On a personal note, working with CAP has been a privilege. I have been inspired by the courage, often in the face of difficult circumstances, the creativity, community support and humour of all – and I do mean *all* – the participants. In the words of one writer: 'It is the creative potential itself in all human beings that is the image of God' (Mary Daly). This project, for me, has demonstrated the wisdom of those words.²

Opening the paint box

There are, of course, many other statements testifying to the value of CAP, and there are the artworks themselves, many of which can be seen within the three multifaith chapels, two Muslim prayer rooms and various corridors (now galleries) within the Sheffield Care Trust, but really the proof is in the practice. And the practice is really quite simple.

Take one chaplain, introduce her to an artist, shake hands and agree on a project. (If you want to run the project yourself, then why not? Just have a go.) For a small scale project, to keep you going for a year, you can set up a weekly art group with basic art materials, such as poster paint, paper, pencils and pens, for a tight budget of £100. If you want to pay your artist, and most artists would appreciate it, you'll need to negotiate a wage. If so, you can source funding through your own employer and other arts and health initiatives, but it would be remiss not to explore the Arts Council resources. If you need to advertise for an artist you can contact your local arts organizations and studios. For artists' contracts you can source those from the Artists' Newsletter website (although you'll need to become a 'temporary' member to do that). You'll also need to make sure that your artist is insured for the project and has undergone an appropriate CRB check. (Information about which can also be obtained from the Artists' Newsletter website.) For

2. There were numerous people involved in CAP, some of whom have been mentioned in Harry's acknowledgement. In addition, I'd like to thank the individual art workshop leaders. These include Akhlaq Indrees (Arabic script), Mike McGabhann (printmaking), Martin Jones (photography), Lizzie von Graevenitz (painting and mask-making) and Penny Whithers (ceramics). In particular, I'd like to thank Sarah Gittins who helped create the mandalas, mosaics tables and wall-hangings. Her contribution to the first six months of the project was vital. The Trust's estate staff also helped install the artwork and gave valuable advice on health and safety issues. Finally, the New Roots Café, part of the Burngreave Ashram, provided, and continue to provide, hospitality for the Drawing Space project.

a larger project you'll need more money and materials, and depending on the scale of the project you'd be advised to employ an artist with a variety of arts and administrative skills. However, the practical process is much the same: set up a table in the chapel, arrange your art materials, have a clear aim in mind but don't worry if you don't achieve it. After all, the creativity - and couldn't we say the same about spirituality? - is as much about the journey as it is about the goal.

Useful websites

Arts Council: www.artscouncil.org.uk

Artists' Newsletter: www.a-n.co.uk

Address for correspondence

For additional information please contact Jonathan Baxter at:
jb4change@gmail.com

Photographs by Jonathan Baxter © 2007

THE JOYS OF THE LIST: TENSIONS AND STRESSES WHEN RECORDING FAITHS IN HOSPITAL

Amar Hegedüs – *Chaplain Lambeth Hospital*

As a reflection of the diverse population of London, we at South London and Maudsley (SlaM) set out to recognize and give due weight to the wide variety of religions represented in our client base. However, the development of our comprehensive Religions List revealed surprises for the whole team.

For example, while the different schools of Islamic jurisprudence clearly need to be included as categories under the general heading of Islam, there are groups that the consensus of Muslim opinion do not accept as Islamic. These equally clearly need to be recorded, not under the general heading Islam, but as an entirely different category.

It quickly became apparent to me such problems are not the exclusive preserve of Islam. I was somewhat surprised when the first list that I presented to my colleagues ruffled some Christian feathers. This resulted in greater attention being taken with other religions and guiding values.

If we truly wish to claim that we serve those in our care, we surely need to take care that they do not feel we are insensitive to their sometimes strongly felt sensitivities and views. The trouble with a 'Religions List for general NHS Use,' is that once it is engraved in the stone of officialdom, it will assume an almost divine authority.

This list was sent to Susan Hollins on May 17th as a contribution to the ongoing process of arriving at a reasonable NHS list.

In allow working chaplains to consider and contribute to the establishment of a cohesive and comprehensive list of Religions and Guiding Values that staff can use as simply as possible, I include for their consideration and comment, the list that we at SlaM currently use:

RELIGION/GUIDING VALUES MENU

AGNOSTIC

AHMADIA/QADIANI

ATHIEST

BAHAI

BUDDHIST

FRIENDS OF THE WESTERN BUDDHIST ORDER

MAHAYANA TRADITION

JAPANESE

SOTOZEN

TAIWANESE

TERAVADA TRADITION

BURMESE

SRI-LANKAN

THAI

TIBETAN

OTHER

CHRISTIAN

BAPTIST

CHRISTIAN SCIENTIST

CHURCH OF CHRIST

CHURCH OF ENGLAND

CONGREGATIONALIST

EASTERN ORTHODOX

GREEK ORTHODOX

INDEPENDENT

METHODIST

PENTECOSTAL

PRESBYTERIAN

QUAKER

ROMAN CATHOLIC

RUSSIAN ORTHODOX

SALVATION ARMY

SEVENTH DAY ADVENTIST

UNITED REFORM CHURCH

OTHER

HINDU

GANA PATYAS (GANESH)

SAIVAS (SHIVA)

SHAKTARS (SHAKTI)

VAISHNAVAS (VISHNU)

VEDANTA

OTHER

HUMANIST

ISMAILI

JAIN

JEHOVAH'S WITNESS

JEWISH

ORTHODOX

UNITED (TRADITIONAL)

CENTRAL (ADATH)

CHARADIM

BELZ

BOBOV

GER

HASIDIM

LUBAVITCH

SATMAR

PROGRESSIVE

LIBERAL

MASORTI

REFORM

OTHER

MESSIANIC JEWISH

MORMON

MUSLIM

SHI'AH

DA'UDI BOHRA

ITHNA ASHARI

ZAYDI

SUNNI

HANBALI

HANAFI

MALIKI

SHAFI

OTHER

PANTHEIST

RASTAFARI

NIAHBINGHI

THE TWELVE TRIBES OF ISRAEL

OTHER

SHINTO

SIKH

TAOIST

UNITARIAN

ZOROASTRIAN

OTHER FAITH

NO FAITH

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A NOTE ON BURSARY GRANTS FOR EDUCATION AND RESEARCH

A glance at the contents pages of the last issue of the Journal was like looking into the file of applications for CHCC grants. Several names were so familiar. It was heartening to see evidence that financial help given to individual chaplains benefits the whole College with the publication of articles, creative pieces and book reviews. So to those who have received grants and have repaid that privilege through this Journal, I salute you.

There are others who deserve to be feted for their part in the Bursary Scheme. Everyone who attends the Annual Study Course is a small contributor to the resource we call the Bursary Fund. If you have attended the Annual Study Course then you have helped colleagues, whether you realized that or not. One further bouquet must be presented to Jayne Shepherd and her predecessors, whose dedicated conference organizing without recompense has ensured the surplus upon which this fund relies.

The College website carries both an explanation of the criteria for awarding grants and an Application Form. These appear at the bottom of the Training and Education page. New members should note that applications can only be considered after six months in membership.

All members need to be aware that the Bursary Fund is limited and that applications for assistance need to demonstrate exploration of other funding sources. In that respect, be aware that Trusts have a responsibility to enable training to meet the Key Skills Framework. Workforce Development Confederations exist to promote training in the NHS as well. Then, of course, there are often faith body funds to support in-service training as well as Charitable Foundations.

Having said all that, I am reminded of what I learned in Cumbria, that 'Shy bairns get nowt!' So don't be shy, do ask and do help us to help you by attending the Annual Study Course. And may our learning enrich healthcare chaplaincy wherever it exists.

Hugh Priestner
Grants Officer, CHCC

February 2007

CREATIVE PIECES

We will remember them? Considering Adult Contract Funerals

After another winter of cold mornings at the cemetery I feel compelled to write something about contract funerals, an area of hospital chaplaincy that is seldom spoken about, or referred to frequently. Yet, this aspect of our work is central to the work we are called to do. For, whilst bedside visiting, and sharing of the Elements at bedside or in the chapel are clearly 'where we are' in the daily routine of hospital care, there is another area which makes demands of us as chaplains, not just emotionally or physically, but spiritually. In my experience, adult contract burials are bleak in every sense, with a scarcity or absence of mourners, coupled with the absence of any knowledge about the deceased making it a hard duty.

It is true that all funeral services make demands on clergy, and this is certainly true of baby communal cremations held monthly. Yet, emotionally demanding as these are, there is attendance by a good number of couples; and through the use of candlelight and carefully selected music in the crematorium chapel, these special funerals create an atmosphere of peace and comfort that we who are conducting the service cannot fail to benefit from.

But, it is the bleakness of the occasion when conducting an adult contract burial service that places this area of Christian ministry in a place of its own. With no known relatives, and no knowledge of the deceased, there is so little to say. On occasions there are loyal and caring staff from a nursing home who show clear affection and respect for the one who has died. In many ways, I am reminded of funerals conducted over remains of servicemen with no ID, whose names are 'known only to God'.

The few lines of prose I have written are my attempt to describe the feelings of isolation, when chaplain and funeral director's bearers 'undertake' this regular duty around the grave, for a soul for whom there is no epitaph, and no headstone. It is the contract funeral that underlines for me the fact that, unless a man or woman in chaplaincy has their Christology sorted out in their mind and holds a commitment to faith in a loving and compassionate creator God, who will do vastly more than we can hope or imagine, such roles as these will be hard, if not impossible, to perform.

AN ASH WEDNESDAY

*It has been a difficult morning...
I don't really want to be here...
"I am the Resurrection and the Life..."
I take my place at the 'head' of the grave.
Like a mantra revolving around my skull
"earth to earth"
and I see the muddy soil pitted with chalk stacked around the open grave, too deep,
with clods set back.
My right hand reaches to the heavens
Where God watches, and weeps, I imagine;
"ashes to ashes"
And the undertaker's men take the strain
Like fishermen returning their catch,
Pulling away support beams
The coffin, with bouquet decorations descends;
"dust to dust, ..." I begin to say then,
"In sure and certain hope..."
but, I pause momentarily...imperceptibly.
Who is this person with no mourners but
Myself and the Funeral Director and men?
Rain slants into my face, spattering the words
Covered sensibly by waterproof paper...
Slowly down, rocking gently to settle forever.
"...of the Resurrection to Eternal Life"
There! I've said it.
Another soul gone to be with God!
"Well done, good and faithful servant" I feel compelled to announce to the men in black.
We are soaking wet, and we turn away;
But there will be another one this afternoon.
Mud clings to my shoes and I am taken back
To memories of battlefield cemeteries,
And remains of a soldier in the Falklands.
"Known only to God..."
Here, dear, sweet Lord is another soul unknown
Except to you.
In Your mercy be gentle and forgiving
To all the sins committed.
The rain has stopped as I drive slowly away.
Sunshine smiles through the weeping windscreen
And it is easier to cope with the afternoon.*

Norman Setchell 2006

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BOOK REVIEWS

Religions, Culture & Healthcare

Susan Hollins

Radcliffe Publishing 2006

ISBN 1-85775-755-6 £16.99 115pp

Susan Hollins has written this useful book from the perspective of one working within the NHS as a healthcare chaplain and as one of the Lead Chaplains taking forward the modernization agenda for spiritual healthcare. Her experience and insight show in this well-written and crafted handbook. The majority of the book is taken up with a similar format reference guide to ten religions and faith groups in the United Kingdom. This provides an easy-to-dip-into reference for such things as attitudes towards Post Mortem, Background and Beliefs to Dress and Attitudes towards death and dying.

In the current healthcare environment it would do no harm for senior managers to read the first two chapters of this handbook. In these chapters Hollins gives a well thought out and uncomplicated introduction to the value of understanding cultural, religious and spiritual needs of individuals in our diverse society. The contribution such an understanding brings to a patient's overall well-being is made clear. So many hospital trusts want to be a patient's first choice when they make the decision of where to attend for treatment. These introductory chapters are a reminder that how the 'whole' person is cared for will determine how a person will view their hospital experience. Hospitals and other healthcare institutions are places where many people feel weak and vulnerable and that they are no longer in control of what happens to them. It is Hollins' aim to promote greater understanding and thereby improve both patient care and experience. Well-being is not just about having dysfunctional body parts mended, it is about respecting the person and ensuring that beliefs, values and culture are considered integral to a patient's care.

In Chapter One, Hollins addresses cultural and religious diversity within healthcare. Chapter Two is devoted to spiritual care. The Equality agenda has changed considerably over recent months as the concept of 'duty' has been introduced. In December 2006 all Trusts had to produce a Disability Duty and in April 2007 will have to produce a Gender Equality Duty. This means that all public authorities must demonstrate that they are promoting equality and avoiding discrimination toward the disabled, women and men. The promotion of equality and elimination of discrimination will eventually cover the full spectrum of equality legislation and will include the provision of goods and services. Susan Hollins's handbook provides a useful reference tool for all healthcare professionals who seek to ensure the well-being and good care for their patients, especially as they seek to provide equality in their provision of care.

Chapter Two with its emphasis on spiritual care is a reminder that healthcare is essentially about people – often about people in crisis seeking meaning and purpose. Hollins reminds us here that the individual matters and that good healthcare should be both culturally and spiritually intelligent. She argues that healthcare institutions can no longer regard questions about personal significance and meaning as peripheral issues as they form a significant part of an individual's well-being. This is not a defence of chaplaincy within the NHS but a reminder that the NHS must have compassion, humanity and 'soul' if it is to provide a comprehensive health service. This book is a valuable contribution to that quest.

David Ashton

Chaplain, Derby Hospitals NHS Foundation Trust

Poppies and Snowdrops: Resources for Times of Grief and Bereavement

Andrew Pratt & Marjorie Dobson

Inspire 2006

ISBN-10: 1-85852-308-7 144pp £9.99

Bereavement and grief is a journey that no human being on this planet can avoid. It happens to us all sooner or later, regardless of our culture or faith. Growing up in Australia and experiencing various cultures there, then in the USA with the Mexicans, immigrants in India with the Hindu faith and now in the UK where I live and work, I have observed various ways people grieve. But one thing remains obvious and constant in all those situations and that is, that losing someone and grieving for them – Hurts! *Poppies and Snowdrops* is an all-inclusive simple resource for times of grief and bereavement, designed to help the reader to find a way through the hurt into eventual healing. Pratt and Dobson had a vision to make the loneliness and pain and often fear of grief easier to bear and I think that that vision has come into fulfilment through the words of this book.

The forward is written by Pam Rhodes. Pam allows us, the reader, to come close to the grief that she once experienced, helping us to see that in the entry of the dark valley of grief we never remain there – there is always an exit. Furthermore, Pam reminds us that God Almighty in his love shows himself to us in the most simplest, yet profound, ways in our grief, perhaps through the neighbour who comes to our door with the casseroles or something else quite unexpected, to aid us in the adventure of the new life that was thrust upon us by our loved one's departure from our lives. Whether that departure was death or abandonment, expected or unexpected, nonetheless- grief, shock and sorrow abound. This book gives us a gift and that gift is the insight that God gives us from time to time to allow us amazing glimpses of His glory through the kindness of others.

This book is not a placebo, it does not give us the feel-good factor but, conversely, it is a brutally honest book. It reminds me of the Laminations and the Psalms of the Hebrew Bible, the Old Testament. Jewish authors never mixed words, if they were upset, grieved, or angry, their prayers contained such honesties. This book is no exception; it reflects those honesties in a beautiful, suitable and meaningful way. The authors allow the spectrum of human thought, emotions and fears to be expressed through the reading and prayers. It also addresses the human condition that hope can be lost in the midst of bereavement; this book makes an impact on the issue of hope. Furthermore, it looks at a faith possibly lost but then gently considers a way to begin to regain it as hope is slowly restored.

Who is this book for? In my view, it is a book for Christians, or someone of no faith and for people of all faiths; it is truly a book for all peoples, who are facing grief in various ways.

The content and language I found to be inspiring, simple to read and self-interpreting. We are all different, and specialized human beings, and we express our grief in different ways. *Poppies and Snowdrops* gives room and ideas for that to happen in a spontaneous, natural way. While working on this book review I have used its contents in liturgy that I had written for two funerals. I found its use to be easy and inspiring as it helped me to express hope, comfort and love to those who were grieving for their loved one.

As we walk in the gardens and fields and see the displays of poppies and snowdrops, which are signs of change in the season, we notice that they are hints of change for the better. These are signs that the winter is now passed and the hope of spring and summer and all that it means is before us. As the reader passes through the season of winter grief that seems to never end, may they lay hold of the hope of the coming of spring and summer and all the newness that it presents.

I commend to you *Poppies and Snowdrops* a brilliant resource for those who are bereaved and for those who serve and take care of them.

Revd Paula Parish-West

Part-time Chaplain, Ashfield Community Hospital

The Challenge of Practical Theology: Selected Essays

Stephen Pattison

Jessica Kingsley Publishers 2007

ISBN 978 1 84310 453 7 pp 304 £19.99

This new volume collects together occasional papers which Stephen Pattison has produced from a range of publications spanning the *Journal of Health Care Chaplaincy* and the *Journal of Local Government Studies*. The book is divided into five parts: Part 1 Ethics and Values in Practice; Part 2 On Organization and Management; Part 3 On Christian Practice and Opportunities: A Critique; Part 4 On Theology and the Christian Tradition; and Part 5 On Pastoral and Practical Theology. Individual chapters cover subjects such as, 'Are Professional Codes Ethical?', 'Some Objections to Aims and Objectives' and 'Dumbing down the Spirit'. In one sense this is slightly annoying (I already have six of the 20 chapters in their original settings). Yet this book does enable the reader to see more clearly the inter-relation and development of Pattison's thinking across both time and through widely varied contexts. It is not a 'smooth' volume, and this makes it more demanding for the reader as the texts have been addressed to very different audiences. The argument of the author is woven throughout each chapter, but it is not, inevitably, built incrementally. The format is therefore in keeping with the author's general view that theology needs to become 'irritating and adhesive'. Those who admire Pattison's work may find here gems not previously encountered, and those new to his writing will get a comprehensive flavour of his work. He is always a theologian willing to challenge, and the chapter containing his polemic epilogue on public theology sets out his concerns about the discipline as a whole. There is a conscious association here with the prophetic role amid the dry bones of abstract theology. Pattison yearns for a more vibrant and relevant role for practical theology. Both the passion and the quality of the analysis are evident, but the concrete steps that will make a reality of Pattison's vision are less certain.

Revd Dr. Chris Swift

President of CHCC

Head of Chaplaincy Services – Leeds Teaching Hospitals

Chaplains have not so far reviewed the following three books. 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.

Making Babies the Hard Way: Living with Infertility and Treatment

Caroline Gallup

Jessica Kingsley 2007

ISBN 978 1 84310 463 6 240pp £12.99

How far would you go to have a baby? *Making Babies the Hard Way* is a frank account of one couple's discovery that they cannot have children of their own, and their ensuing struggle through four years of fertility treatment.

One in six couples worldwide seek assistance to conceive and 80% of couples undergoing fertility treatment are currently unsuccessful.

Writing with humour and honesty, Caroline Gallup describes the social, emotional, spiritual and physical impact of infertility on her and her husband, Bruce, including feelings of bereavement for the absent child, the unavoidable sense of inadequacy and the day-to-day difficulties of financial pressure. As well as telling her own moving story, she also offers information and guidance for others who are infertile, or who are considering or undergoing treatment.

This courageous and poignant book will be of interest to couples who cannot conceive and those who are undergoing treatment, as well as their families and friends.

Praise for the book:

'If you read this book you will discover what to expect if you learn that you cannot have babies the easy way. You will also be helped to face what is often the hardest decision for couples struggling to make babies with medical help: how and when to stop trying. Few books on infertility will have so much impact because few authors have Caroline and Bruce's courage to allow the emotional pain of infertility to transform them and their relationship. Much more than an infertility survival guide, Making Babies the Hard Way tracks a journey which starts and ends with love. It is at once a witness statement and an inspiration.'

Dame Suzi Leather,

Chair, The Charity Commission, UK,
and former Chair, Human Fertilisation and Embryology Authority, UK

Silent Grief: Living in the Wake of Suicide (Revised Edition)

Christopher Lukas and Henry M. Seiden

Jessica Kingsley 2007

ISBN 978 1 84310 847 4 176pp £13.99 (Paperback)

Silent Grief is a book for and about 'suicide survivors' – those who have been left behind by the suicide of a friend or loved one.

Author Christopher Lukas is a suicide survivor himself –several members of his family have taken their own lives – and the book draws on his own experiences, as well as those of numerous other suicide survivors. These inspiring personal testimonies are combined with the professional expertise of Dr. Henry M. Seiden, a psychologist and psychoanalytic psychotherapist.

The authors present information on common experiences of bereavement, grief reactions and various ways of coping. Their message is that it is important to share one's experience of 'survival' with others and they encourage survivors to overcome the perceived stigma or shame associated with suicide and to seek support from self-help groups, psychotherapy, family therapy, Internet support forums, or simply a friend or family member who will listen.

This revised edition has been fully updated and describes new forms of support ,including Internet forums, as well as addressing changing societal attitudes to suicide and an increased willingness to discuss suicide publicly.

Silent Grief gives valuable insights into living in the wake of suicide and provides useful strategies and support for those affected by a suicide, as well as professionals in the field of psychology, social work and medicine.

Grandad's Ashes

Walter Smith

Jessica Kingsley 2007

ISBN 978 1 84310 517 6 32pp £8.99 (Hardback)

This beautifully illustrated full-colour picture book for children, aged four to eight, tells the story of four children who embark on an adventure to find their Grandad's favourite place – but they are faced with plenty of challenges on the way.

Told with gentle humour, this is a charming story for children and an ideal resource for parents or counsellors to read with a child as a way of broaching issues surrounding loss or bereavement.

Extract from the book:

When Grandad died, eighty-three people went to the funeral. A lot of them cried. Jessica, Colin, Sasha and Tom thought of the good times they'd had with their Grandad. They knew they would miss him a lot. "He had always wanted to be cremated," said Grandma, 'and his last wish was to have his ashes scattered in his favourite place...'

Books received for review

The following books are awaiting a chaplain to review. Please contact John Wood if you are interested in reviewing any of these titles or are someone who would be interested in reviewing new titles.

Christian Congregations and Mental Illness

Edna Hunneysett

Fryup Press 2006

ISBN 978-0-9545951-3-5 234pp £12.00 (Paperback)

Health Care and Implicit Religion

Roger Grainger

Middlesex University Press 2002

ISBN 1-898253 46 3 230pp £19.99 (Paperback)

New Journeys Now Begin: Learning on the path of grief and loss

Tom Gordon

Wild Goose Publications 2006

ISBN1-905010-08 7 286pp £11.98

We need to talk about the funeral: 101 practical ways to commemorate and celebrate a life (2nd edition)

Jane Morrell and Simon Smith

Accent Press 2007

ISBN 978 1 90612 501 1 208pp £14.99

Who is Muhammad

Khurram Murad

The Islamic Foundation 1998

ISBN 0 86037 290 1 40pp £3.94

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.

Submission Dates

Articles submitted for consideration should be sent to the editor by 30th January for inclusion in the spring/summer edition and by 30th August for the autumn/winter edition. Late submissions are welcome at the editor's discretion. A special third edition is produced electronically each year to record papers from the CHCC annual study course and lodged on the website.

Review Articles

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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Publishers or authors wishing to have a newly published book reviewed should contact the review editor:

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If you have read a recently published work of direct relevance, do contact the book review editor or submit a short review.

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