The Journal of
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Editorial

Meg Burton

My first task, as I take over the reins as editor of the *Journal of Health Care Chaplaincy*, is to apologize for the length of time since the last edition and to thank all of you, readers and contributors, for your patience. The editorial team, which now includes Chris Swift, are greatly encouraged by the number of articles that have continued to be sent in during the interregnum, and we hope that you like the slightly changed format internally and the revamped cover design.

Our thanks go to Simon Harrison, who led us so well over several years and who set a high standard of articles to be included in the Journal. And thanks, too, to Steve Nolan, who so ably Guest Edited the last edition.

In the past we have had main articles that have clearly been academic, supported by shorter ones and creative pieces. This time the articles seemed to fall quite naturally into headings – professional issues, mental health, multi-faith, palliative care and general interest – and are a mixture of different types of writing.

There are two professional issues that are concerning most chaplains at the moment – the possibility of us becoming a 'profession' and the registration that would then become compulsory, and the place of supervision as a support for us in our day-to-day practice. Andrew Haig has given permission for us to publish a sermon he gave at Norwich Cathedral which addresses in a most moving way the dilemma, as he sees it, of us becoming a 'profession'. This is supported by a report by Clive Smith of the seminar on 'Maintaining Registration' that was held in London in June 2010.

Martin Kerry is treasurer of APSE (Association of Pastoral Supervisors and Educators) and gave a presentation on supervision at the East Midlands Meeting of CHCC members. He has written this up for us. Richard Lowndes has been involved in supervision for many years, both as supervisor and supervisee. He shares with us his experiences and the value he and his team have found in being able to look at their practice in a safe environment.

All of us, whether we are specifically chaplains in the mental health sector or chaplains in the acute sector, are dealing every day with people

whose illnesses affect their mental well-being. And when we are both physically and mentally out of kilter, this will also have an effect on our spirituality and how we view religion. This could equally well affect us positively as negatively. Rachel Freeth and Madeleine Parkes have both given papers at Mental Health Chaplains' Study Conferences and share their research and findings with us. These articles are followed by James Hair's findings about the place of hope and prayer in mental health.

Written after reading an article in the *New York Times* last autumn, and to answer a colleague's question, Amar Hegedüs offers us a thought-provoking article on the Islamic theology that underpins his chaplaincy work. An ancient tool to help people engage with the spiritual side of themselves, particularly, but not exclusively, as they approach death, is the labyrinth. Lizzie Hopthrow's very interesting article gives us the history of the labyrinth and shows the benefit one hospice has found in having a permanent one built.

In these days of threatened cuts it is all the more important that the work of chaplains is explained and promoted. John Sherbourne's magazine, *Chaplaincy Matters*, does just that. It is also very pleasing to read of Charlie's Miracle – pleasing that Ruth Jolly's son survived his accident, and pleasing that she has taken the trouble to write about the support the chaplain gave to them and the benefit they derived from that contact.

Those of you who read the Journal from cover to cover will notice a page with the heading 'Endpiece'. This time it is a short poem, but it may be a short reflection or a question or dilemma someone has been thinking about, which could be offered as something to end the Journal.

The *Journal of Health Care Chaplaincy* cannot exist without your contributions. I hope that what you read in this edition will encourage many of you to put pen to paper, in the form of a letter, perhaps, or a responsive article, writing up some research you are doing, an article on a chaplaincy-related issue about which you are passionate, or an Endpiece. We already have three potential articles for the next edition and are hoping to be able to publish by the end of the year.

Meg Burton
Worksop
August 2010

A Sermon

Revd Andrew Haig was Senior Chaplain at the Queen Elizabeth Hospital, King's Lynn. He preached this sermon on Sunday 4 May 2008 in Norwich Cathedral.

Well, this is all very different from my normal setting. It's all so very grand! This building: so glorious, and so big. Coming from where I come from, it's a good thing there was a verger to lead me to the pulpit. Would I have found my way without him?

It's all so *glorious*. And what a Sunday to be invited to preach! – because today is all about *glory*. It was all there in the Ephesians reading, about Jesus being exalted to a glorious throne – high and lifted up. And it all fits together, because here too is a throne, all high and lifted up. Not very high perhaps in comparison with the throne to which Jesus is exalted, but pretty high in my eyes. You see, I work in a hospital, and we haven't even got a chapel at the moment. We worship in a conference room. And once you've put a couple of beds and a dozen wheelchairs in it, it's just about full. And there's no verger to lead me anywhere. There's nowhere to go. So yes, for me this is all pretty glorious.

Actually, the world around us knows all about glorifying people – though 'glory' is not a word used much. There are others – 'respect', 'adulation', 'admiration', 'recognition' perhaps: all a bit different, but each in the same sort of area. Anyway, the world knows all about setting people up on thrones and bowing down to them. You have only to be very good at football, say – or snooker, or entertaining people – and the world will give you glory.

And it's there that the sort of glorification we're thinking of today – the sort of glory this cathedral may symbolize – is rather different. Glory as the world understands it goes with achievement, with success, with glamour perhaps. For Christian faith glory goes with a cross. And that's a strange sort of teaching if you think about it: your true glory lies not in the things you achieve but in the things you suffer. What makes you *special* is not anything you do or achieve, but what you suffer.

It is a strange teaching and worth exploring a little. And since it is also, as

I see it, closely related to what is going on in the world of hospital chaplaincy at present, let me go down that road to explore it.

I became a hospital chaplain a long time ago: over seventeen years. And in those days it was fairly clear what a hospital chaplain was. A hospital chaplain was a Christian priest – almost certainly a Church of England priest – who had decided to work in a hospital rather than as a parish priest. A chaplain was always an odd sort of creature – sort of neither fish nor fowl – because priesthood belongs to the world of religion, whereas the National Health Service is very much a secular organization.

But it was on the whole a happy sort of relationship. Most of the people who worked in the hospital had very little idea exactly what a chaplain was. But nobody really minded much. By and large, management felt that chaplains were good people to have around, and they didn't cost too much. And the world I entered in the hospital at King's Lynn was pretty much bliss really. I felt incredibly welcome and wanted. And nobody asked me to account for my time or anything like that. They just seemed pleased to have me around. Can you imagine anything so delightful! And so far as I was concerned I was simply a priest – in a different setting, to be sure: less concerned with religion specifically, more concerned with things pastoral and spiritual. But in my mind I continued to be simply a priest.

How different is the world today. All sorts of things have happened to change it. But the biggest thing driving change is probably money. The NHS is – by definition almost – never going to have enough of it. Hospital Trusts up and down the land have been desperately making savings. And of course chaplaincy has felt itself to be under threat – perhaps the first thing for a secular organization to feel it can cut. You can't really have a hospital without doctors or nurses, but you could have one without chaplains.

And that sense of threat has had a radical effect on chaplaincy. The argument has gone basically like this. If chaplaincy is to survive, we will have to learn to justify our existence – and to do so in language our managers understand. Now, our managers only understand activity, and things that can be counted. So we have to learn to tell the world in general and our senior managers in particular exactly what we do and why we do it, and how useful it is, and how little it costs for the benefit it produces. In other words, we have to sell ourselves. The big question becomes: How do we ensure that chaplaincy enjoys the respect we think it ought to have? I use the word 'respect', but I think I'm talking about what our readings might call 'glory'.

And the answer chaplains have come up with is that to enjoy the respect we deserve we need to become a properly recognized profession, in some ways, at least, like all the other professions in the NHS. And so there is a great drive at present for us to *define* chaplaincy, to put down in writing exactly what chaplains do; to produce standards documents and competencies documents, and knowledge and skills frameworks; and to create the sort of career structure other professions might have – of 'assistant chaplains', 'chaplains', 'senior chaplains', 'specialist chaplains', and 'consultant chaplains'; and to get ourselves officially recognized as a healthcare 'profession'. Indeed, one of our recent annual conferences was entitled: 'Chaplaincy, the New Profession?' We are to be healthcare professionals – experts in spiritual care.

And I worry. I fear that to set ourselves up as a new profession is dangerous, and may be positively damaging.

What exactly is a 'professional'? Well, of course you could spend days just discussing that. It can mean many things. But what exactly is a 'professional' as it might be understood in the NHS? The picture it brings to my mind is of a person possessing a particular body of knowledge and a particular set of skills that make her or him an expert practitioner in a particular field. That picture makes sense when I think of a physician, or a physiotherapist or a pharmacist, etc. But the idea that you can think of a chaplain as practising something called 'spiritual care' on that sort of model fills me with horror.

And it just does not ring true to the way things are. An example: Last Thursday. Ironically, the day looked relatively clear in the diary, and I had hopes that I might spend an hour or two getting this very sermon written. Fool!

At ten to six in the morning the phone rang. 'Hospital switchboard. They want you in theatre recovery. I'll put you through.' 'Hello, Andrew, we've had a child die. The family are here. Could you come, please?'

Little James – we'll call him – was 8 months old. He'd been in hospital quite a bit in his first three months, but better since Christmas, his problems apparently behind him.

Goodness knows what went wrong last Wednesday night – the post mortem should reveal that. But he came into hospital in the night very poorly. The doctors were anxious. Conversations took place between them and colleagues at Addenbrookes and Great Ormond Street. And it was decided to transfer him to Great Ormond Street. Various bits and pieces

I would not understand needed to be done to stabilize him for his journey while they waited for a team from London to come for him. But he went into a steep decline. Three times he arrested. The first two he responded readily to resuscitation. The third time not. And he was gone.

When I arrived, there were his parents, both their mothers, and the sister of one of them, and one little body lying there – still warm and fairly pink, but dead. And you feel so utterly useless. You sit there, and there's nothing for anybody to say. And you give one or two tentative little hugs or hand grasps while they weep. And soon you ask if you can say a prayer for little James. Yes, please. And gradually you begin to talk a little about him, and they tell you what a cheerful little chap he's always been, and they show you his one tooth. And eventually you say something like: 'I've no idea if you're at all religious or not. And I don't care at all whether you are or not. But if you would like me to bless him or baptize him, you must say so.' And his Dad says, 'Well, no, we're not religious really. But his Nan is, and I think she'd like to know he'd been baptized.' And James's Mum says: 'Actually, I'd like that too.' So you baptize this lifeless little form, becoming cold now and deathly pale. And soon after that the family just need to get out for a while – for some fresh air. And they ask you if you would stay with James while they're gone. And I tell you, if anything ever felt like a sacred trust, then this is it. Two young parents entrust their dead baby to your care. You sit beside this little body and stroke his soft, soft hair. And then the two nurses who have been hovering come, and you all hug each other and cry. And then you hold James while they tidy up the bed. And the parents come back. And as the hours go by, you feel that you come incredibly close to this family, and they even give their consent for you to talk about them in Norwich on Sunday.

Now hospital chaplaincy is not always – not often – as intense as that. But if anybody asks me to give an example of what it is really all about, it is to experiences like that one that I will point.

Did I come to that family as some sort of spiritual expert, bristling with knowledge and skills to diagnose their spiritual state and prescribe something to put them right? Of course not. I did not come bringing any sort of expertise. The only thing I had to offer was me. One person coming alongside some others.

At the end of the day, as I understand it, spiritual care really simply means loving people. Coming alongside people and being with them. 'Alongside' is something of a key word for me. And the one thing it seems to me that you

really cannot be a 'professional' at is loving people. Being a professional in an NHS sense precisely *prevents* you coming alongside people, because it puts you *above* them. Think of a doctor. I lie there in my hospital bed because there is something 'wrong' with me. And the doctor is the professional, the expert, with the knowledge and the skills to put me right. And very necessary it is, too. But there is no equality in the relationship: I am down here and she or he is the expert: up there. Not alongside.

So I worry about chaplaincy and its future. We have convinced ourselves that unless we become 'professionals' we shall not be valued, and chaplaincy will be cut until it is dead. I do not actually believe that. I have now worked with five Chief Executives. Not one of them has wanted me to account for what I do. All of them appear to have believed that chaplaincy matters and is something that cannot really be defined and enumerated. Perhaps I have been unusually fortunate, but I do not think that most of our managers are the soulless barbarians people apparently take them for. They may or may not understand our spirituality, but I believe they recognize that there are things crucial to human health that are intangible and cannot be counted, and that chaplains somehow come into that area.

Wouldn't it be ironic if, in our zeal for the future of chaplaincy, we were to seek and achieve the worldly recognition of professional status, thereby destroying our ability to offer the greatest gift we have to offer to the NHS – the ability to come alongside people in a way that no expert ever can?

You cannot be a professional lover. My ability to come alongside people has rather little to do with knowledge or skills, and rather a lot to do with how much of my time is spent, either literally or figuratively, on my knees, because it is only insofar as I am in touch with my own weakness and vulnerability that I can come alongside others in theirs.

Hospital chaplaincy in my book is all about loving people. Christianity is all about loving people. And God knows that we are none of us very good at doing it. But it is our calling, and it has to mean being alongside people. A loving God has to be an incarnate God – alongside us, not above us. The story of the Incarnation, which ends on a throne high and lifted up, is paradoxically a story not of ascent but of descent; of a God who comes down from a heaven – right down to a human death on a cross. Christ's true glory, your true glory, my true glory, lies in the way of the cross. Seeking worldly recognition is foreign to our calling as Christians, and I doubt it will serve chaplains well.

It's all part of the topsy-turvy paradoxical world of Christian faith. Being high and lifted up means going down, not up. And now I had better come down from here, for your sakes, of course, but also for mine. Because being so high and lifted up is probably very bad for me.

Correspondence

Revd Andrew Haig
46 Elvington
King's Lynn, PE30 4TA.
Email: bandahaig@yahoo.co.uk
Tel: 01553 761389

Professional Registration for Chaplains Seminar: A Report

Revd Clive Smith is Trust Chaplaincy Manager, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, and the Yorkshire and Humber Regional Representative on CHCC National Professional Council.

Introduction

As I was walking from King's Cross Station to this seminar, on 22 June this year, I saw a poster outside the British Library with the following quotation from Marie Curie: 'Nothing in the world is to be feared. It is to be understood.' For some chaplains the idea of professional registration may be an alien concept and, if not feared, then at least something with which they may not feel comfortable. For others, it may be something of a holy grail and, once we are all formally registered and regulated, all will be well in the chaplaincy world. This seminar was aimed at helping chaplains understand the background to current moves towards registration and the progress that has been made to date. It was ably led, with typical good humour and understanding, by Malcolm Masterman, Lead Chaplain at South Tees NHS Foundation Trust and a board member of the United Kingdom Board of Healthcare Chaplaincy (UKBHC).

Defending Chaplaincy

In total, 18 people, including CHCC's Professional Officer, Carol English, and its Registrar, William Sharpe, attended the seminar. The first session of the day was given over to a presentation on defending chaplaincy from the threat of financial cutbacks. Malcolm was supported in this by Carol, who said that the number of concerns about financial cutbacks had increased hugely. The essence of the presentation can be found in the members' section of the CHCC website (at: www.healthcarechaplains.org). It contains much useful advice, including the importance of record-keeping so that chaplains can demonstrate what we do. The current situation, while clearly very serious, is not the first time that many chaplains have felt threatened and marginalized.

CHCC can provide further advice about what would be helpful in maintaining the level of your service, with both positive suggestions of what to do (e.g. obtain the support of Governors if you are a Foundation Trust) and cautions against taking some options which may be offered. Members can always contact their regional representative or Carol for support if they are facing cutbacks to their budget.

The Story So Far

Malcolm then led the rest of the day and started by outlining the background to the formation of UKBHC and how it is has built upon the work of CAAB (Chaplaincy Academic and Accreditation Board). The idea of registration is not new. The College has had a Registrar ever since its formation in 1992. I served on the then Council of CHCC over 10 years ago and the subject was an important one on the agenda then. There are now over 400 chaplains on the UKBHC register. Talk about registration inevitably led to some lengthy discussion about the tensions and difficulties that have arisen between the various chaplaincy organizations over the last eight years or so. It is clear that no one is, or has been, happy with the situation. Following the review of HCC (Hospitals Chaplaincies Council), its reception by, among others, CHCC, and the acknowledgement by many that 'taking chaplains with you' in this process is vitally important, it seems to many that we have an opportunity now to move forward constructively and positively. Dare I ask, are we at what the New Testament would call a *kairos*?

As in many things, it is important to understand the purpose of professional registration. The argument that carries most weight with me is that it should and could lead to better care of patients – that patients and others can be assured that the chaplain who appears at their bedside is someone who has knowledge, skills and authority, and is a person who can be trusted. It is not, or should not be, about power, status or control. It was emphasized several times that the authorization of a chaplain by his or her appropriate faith community is a vital part of the process. The relationship between the chaplaincy membership groups and the faith communities has been felt by many to be an area of conflict. It should be one of cooperation and partnership. Malcolm was very clear in stating that UKBHC was not in any sense 'anti-religion' or following some sort of secular agenda and that it had published documents to this effect. My own personal view is that

accreditation from a chaplain's faith community is not just a prior condition of practising as a chaplain but is an ongoing necessity, just as is our learning, reflection and good conduct. When I stand beside the bed of a patient, I am there not only as a professional chaplain but also in part as the representative of a faith community.

The Role of Advisors and Code of Conduct

Malcolm explained the role of the advisors in the appointing process, ongoing support and giving advice to chaplains. They are concerned about the level of skills and knowledge that candidates may have for the particular post for which they are applying. They are concerned that the appointment process is fair and without bias. They can also advise on such matters as job descriptions and person specifications and the appropriate terms and conditions for the particular post. An advisor may also be somebody a chaplain (or Team) can turn to for support if they are facing cutbacks or other problems.

As the group had spent much time in discussing the various earlier items on the agenda, it was not possible to spend time dealing in detail with the newly revised Code of Conduct. It is freely available to read on the UKBHC website (at: www.ukbhc.org.uk/). The importance of it is that chaplains are dealing on a day-to-day basis with people who are vulnerable and assume that we are honest and trustworthy in all things. It is a privilege and very humbling to be with people at some of the most significant times in their lives. To most of the patients we encounter we are total strangers, yet we are trusted. That trust must not be abused. Our relationships are too precious to be put in jeopardy by bad conduct.

Conclusion

When the seminar was over, and as I had plenty of time before my train home, I returned to the British Library and visited their current exhibition about maps. While not confessing to being a 'map addict', I do like looking at them and maps are often very fascinating. They can be very beautiful and as much works of art as useful aids. They have in the past been used as tools of propaganda and devices to exercise control over others or to make bold statements. If you are lost and are not sure in which direction you should be going, a map can be both very helpful and reassuring. In a way, this seminar

was a bit like a map. It helped us understand where we have come from and perhaps pointed out where we might be going. It may well have helped allay the fears and concerns of some of the participants. It was made clear that if professional registration is to happen under HPC (Health Professions Council), it will still take a number of years. UKBHC will itself change in time; it is, for instance, seeking to appoint some 'lay' members and is aware of the need to communicate and consult better with working chaplains. The organization is barely two years old and is very much a 'work in progress'. Having a 'map' to help you on the journey is always helpful and this seminar was a useful aid to help us on our way.

If any one would like a copy of Malcolm's presentation they are welcome to contact him, or me, for an electronic copy.

Correspondence

Clive Smith
Email: Clive.smith2@dbh.nhs.uk

Malcolm Masterman
Email: Malcolm.Masterman@stees.nhs.uk

An Introduction to Pastoral Supervision

Revd Martin Kerry is Senior Chaplain and Chaplaincy Manager at Sheffield Teaching Hospitals and Treasurer of APSE (Association of Pastoral Supervisors and Educators).

Supervision – What Is It?

According to the APSE definition:

> Pastoral supervision is a regular, planned, intentional and boundaried space in which a practitioner skilled in supervision (the supervisor) meets with one or more other practitioners (the supervisees) to look together at the supervisees' practice.

It is not spiritual direction, counselling or line management. Pastoral supervision is also, *inter alia*, spiritually/theologically rich, contextually sensitive, praxis-based, a way of growing in vocational identity, and attentive to issues, such as fitness to practise.

Characteristics of Supervision

A classic way of describing supervision is in terms of normative, formative or restorative elements.

'Normative' deals with managerial issues and boundaries, e.g.

- Is the supervisee safe to work with others?
- Are there issues of competency to address?
- What policies and procedures does this supervisee need to work to?
- What codes of ethics are relevant and are they being adhered to?

'Formative' deals with developing the supervisee through, e.g.

- guidance on how to interpret or handle situations;
- improving skills;
- increasing self-awareness;
- introducing new areas of knowledge/suggesting reading;

- suggesting different perspectives or ways of tackling things;
- encouraging growth and change;
- rehearsing new strategies or roles.

'Restorative' supports the supervisee through, e.g.
- active listening;
- encouragement;
- feedback;
- opportunity for discharging feelings;
- helping the supervisee connect with his/her vision/sense of vocation;
- helping him/her recover parts of the self that have got lost in the work;
- recharging energies. (adapted from Leach and Paterson 2010)

A competent supervisor will be able to hold all three elements, bringing each one to the fore as appropriate.

Why Have Supervision?

(a) Supervision underpins fitness to practise. The normative element ensures safe and ethical practice. The formative element encourages practitioner development. The restorative element helps protect from burnout. 'Supervision … provides a container that holds the helping relationship' (Hawkins and Shohet 2006).

(b) This stance on supervision is supported by professional statements:

Who requires supervision? – Any practitioner requiring a space to reflect upon and learn from their work. (www.ukbhc.org.uk)

As part of the process of continuing professional development, the chaplain demonstrates the ability to reflect upon practice in order to inform his or her practice. (UKBHC: Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains 2009, standard 4.1)

All chaplains have 'access to external professional supervision'. (UKBHC: Chaplaincy Service Standards 2009, standard 6a.10)

(c) Blocks to receiving supervision might include practical reasons (money, time, distance to travel); resistance (to self-scrutiny or to receiving support); difficulty finding a supervisor; or thinking 'What's the point?'

How Is Supervision Done?

(a) Models of supervision include:
- Action and reflection, i.e. chewing it over, which might lead to unexpected insights.
- Kolb's experiential model (quoted in Foskett and Lyall 1988), i.e. experience → reflect → discover meaning → experiment and anticipate future experience.
- Gerkin's (1984) hermeneutical model, i.e. overlapping stories: patient/faith tradition/chaplain; attending to the points of intersection.
- Hawkins and Shohet's (2006) process model, i.e. the 'then and there' in a pastoral encounter; and the 'here and now' in the supervisory relationship.

(b) Methods of supervision might include:
- verbal report
- verbatim
- process report
- case study
- critical incident report

(c) Types of supervision might be:
- individual or group
- facilitator or peer
- tutorial, managerial, consultancy

When finding a supervisor, we need to ask ourselves what it is we are looking for. To clarify our thoughts, Leach and Paterson (2010) suggest we list the characteristics we would like in our 'dream supervisor' and those in our 'nightmare supervisor'.

If we are having problems finding a supervisor, we might consider contacting other healthcare professionals who have a tradition of super-vision, e.g. clinical psychologists.

Supervising Others

> The first pre-requisite for being a good supervisor is being actively able to arrange good supervision for yourself. (Hawkins and Shohet 2006)

Resources for supervising include APSE, training courses and reading:

(a) APSE is the Association of Pastoral Supervisors and Educators. Its purpose is to promote high standards of pastoral supervision by:
- providing a system of accreditation for pastoral supervisors and educators in pastoral supervision;
- supporting initiatives in the training of pastoral supervisors;
- fostering groups for the support, accountability and continuing development of pastoral supervisors;
- encouraging conversation among the various traditions and contexts of pastoral supervision and pastoral supervision education.

Membership of APSE costs £20 p.a. for individuals and £130 p.a. for institutions.
   More details can be found at: www.pastoralsupervision.org.uk.

(b) Training in supervision is available generally for counselling contexts, and in a more limited way for some healthcare and Christian ministry settings. Courses held in Edinburgh and Cambridge are specifically geared to healthcare chaplains. A discussion needs to take place within the profession about the desirability of more widespread dedicated training.

(c) Reading – see below.

Acknowledgements
These notes are based on a presentation given to the East Midlands branch of CHCC in June 2010.

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Correspondence
Martin Kerry
Email: Martin.Kerry@sth.nhs.uk

Supervision Five Years On

Revd Richard Lowndes is Senior Manager for Spiritual Care, Bereavement Care and Voluntary Services at Southampton University Hospitals NHS Trust.

Abstract

We talk about supervision, but do we know the benefits gleaned after regular use of supervision and do we take self-care seriously enough to make supervision an essential part of our role and practice in supporting patients, relatives and staff?

Key Words
Healthcare; Professional; Chaplain; Supervision; Supervisee; Supervisor

Main Article

When I first arrived in Southampton in 2003 I had come from a background where I had found supervision personally very useful (while undertaking a counselling training). I also had become more aware over the years of clergy who did not have supervision or spiritual direction and who accessed little or no support of any kind. For me this meant that there was no system built in to check on their practice ethically or in relation to boundaries, and no sounding board for exploration when they were feeling stuck with a situation or manipulated by a parishioner/patient/client/colleague. Another principle affecting the background to this article is the high level of self-awareness I believe to be necessary for us to work effectively and safely within the field of healthcare chaplaincy (or any ministry, come to that). The NES Scottish document (2008) *Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains* (at: www.nes.scot.nhs.uk) is a useful one relating to relevant standards and skills in our area of work.

On arrival in Southampton, I was heartened by the receptiveness of the Trust in relation to putting this support in place. If we are not keeping support in place for ourselves, how on earth are we meant to offer it to others? So, provision was made in our budget for supervision to be offered monthly on an individual basis (I know that there are examples where spiritual care teams also receive group supervision – we have also built in a weekly time where we reflect in a peer group about our energy levels and the dynamic of the team). This monthly provision does not compare favourably with the recommended hours of supervision which practising counsellors have, but, taking into account the varied nature of our work and the fact that not all our time is spent working on a one-to-one basis, it seemed a reasonable expectation and a good start.

Supervision in Context

Having said this, we soon found ourselves working in an environment of financial cutbacks, where it was necessary to reduce the workforce and we saw our staff support figures increase by 165 per cent. This was followed by a reduction in size of our own team, and so you can see already that the workload for each chaplain, as well as the background environment, changed enormously.

We are now more than five years on with this incentive and I thought this would be a good time to review the benefits of such a system and to ask some structured questions of myself and of my colleagues about what difference it might have made to their working life and self-awareness, their working practice with individuals and groups, their spiritual direction (if that is their custom) and their sense of reflection on ethics, boundaries and practice.

Supervision in Practice

Each individual has set up regular meetings with qualified supervisors from the world of counselling. These supervisors are either registered with the British Association of Counselling and Psychotherapy or the United Kingdom Council for Psychotherapy (UKCP) and therefore work within a strict code of practice (see: www.bacp.co.uk; www.psychotherapy.org.uk) which I believe also fits well with the world of spiritual care.

Supervision under the Microscope

In compiling the list of questions below I worked closely with our Clinical Effectiveness Department so that we could extract the fullest evidence possible.

A series of ten structured questions were put to chaplains receiving supervision in the Southampton team. All the responses from chaplains recorded here are from those who have received supervision in this work for at least five years. Each of the chaplains works whole-time and has responsibility for specific clinical areas. Six chaplains' responses are represented here. The questions were the same to each chaplain and were as follows:

Structured interview:

1   How do you view your supervision?

2   What difference has supervision made to your levels of self-awareness and your overall personal development?

3   Has your insight and use of boundaries changed as a result of supervision?

4   Is there an element of ethical exploration in your supervision and, if so, what have the benefits been?

5   Has supervision changed the way you view other forms of support (e.g. spiritual direction) in your life?

6   Are there any deficiencies in receiving supervision from someone from the world of counselling?

7   Would you say that supervision has helped you reflect more on your practice?

8   If supervision was withdrawn, what would you miss about it?

9   What overall benefit would you say that supervision has for your work with patients, relatives and staff?

10 Is there anything else you would like to add about the benefits/drawbacks of supervision?

The responses to this questionnaire were obtained after a facilitated reflective away-day to look at our practice in relation to staff support, so reflections about supervision are very present for the team.

Survival

'Sometimes it's a means of survival.' For me this means that at the least supervision is a useful breathing point in our practice for us to reflect; indeed, at times it might be the necessary safety net which forms part of the support to our work.

Self-awareness

Self-awareness is a particular interest of mine and a core skill for any chaplain. I was interested to discover whether chaplains who had experienced supervision over this length of time had perceived any difference in their levels of self-awareness and overall personal and professional development. Here there was a general feeling that as a team we were quite good at reflecting and being self-aware. Again, the opportunity to stop and reflect was good, and the specific aspect of seeing things in perspective and reflecting on personal impact was helpful, as well as offering an opportunity to check out competences and receive current information and articles from supervisors, depending on the expertise or specialism of the supervisor (examples were quoted from information on people experiencing 'flashbacks' to reflections on organizational structures, frameworks and cultures). Here it's probably appropriate to add that another influence in the development of self-awareness and awareness of each other for the team has been a series of team development days (including Myers Briggs from a team perspective).

Boundaries

When asked specifically about boundary issues, most chaplains questioned stated that they had done a lot of work around their boundaries prior to receiving supervision and that supervision had reinforced and given additional confidence in the good use of boundaries, especially when dealing with complex situations and circumstances where we might otherwise feel manipulated.

Ethics

Ethical reflection in supervision stood out in this questionnaire as a means of examining situations which compromise us or the patients, families and staff we work with. One chaplain reflected that 'it's my means of assessment of whether to speak up or not' (in cases that would otherwise be unclear). Examples were cited in which ethical reflection had been the means by which decisions had been made in how to proceed in a particular situation.

Support

'Supervision has heightened my awareness of the need for self-care, which in turn has fed my motivation to do something about it.' 'It's resulted in a temporary disruption of my spiritual support because I was getting the support I needed in supervision.' 'It's given me clarity about the differences between line management and supervision … clear about what we are there to do.' Often, as chaplains, there are questions about who we are in any particular role. For me personally, it has been between the management functions: counsellor, supporter, chaplain, priest, NHS employee – to name but a few. These roles all sound distinct from one another but in practice soon begin to overlap. What do you do when you are supporting a member of staff and they disclose that a member of the local clergy has come into the hospital and behaved inappropriately and, moreover, what does it do to the relationship of trust with the staff if you decide to take action on what turns out to be a serious incident? For me, supervision is a safe arena in which to explore these issues. Clarity about what we deal with in which place can lead to an important, appropriate and healthy exploration of support, ethics and boundaries.

Who Is the Supervisor?

Now the knotty problem of who is able to give supervision. My main concern when I set up this initiative was to ensure the safety of those being supervised and therefore the ultimate safety of those to whom we minister/ offer support. Therefore, to go down the route of properly registered and highly trained supervisors from the world of counselling who have a clear code of ethics seemed obvious. This is the background to asking the question about whether chaplains perceive any deficiencies in being supervised in this

way. One respondent laughed and commented that there were no deficiencies, especially considering the nature of the work that we do. In general, there was an acknowledgement that supervision is for something distinct, related to the support of clinical practice and that to be working with a highly trained practitioner from a similar field was helpful.

What Would Our Work Be Like without Supervision?

When asked what the impact of withdrawing supervision might be, there was universal outcry. One powerful response was the loss of 'a safe place to reflect and learn', and from another chaplain, 'sometimes I'm waiting from month to month to go'. It would mean a great loss of 'support', that 'external, sympathetic, sounding board'.

Interestingly, the responses to the question about overall benefit were around quality, the quality of the work we do and our professional response to taking responsibility for the work we do. There were references to supervision helping to keep the focus on the work, especially complex situations. 'They probably get a saner chaplain as a result of supervision'.

This leaves us with the 'any other comments' question. As you will have gleaned from the above, the whole team has been enthusiastic about their supervision and have seen it as being of benefit; indeed, it has become an integral part of safe clinical practice and so it will not surprise anyone to hear the final comments of 'I could do with it weekly not monthly' and 'I would recommend it to anyone working in the support of others'.

On a practical note, it has generally proved easier to place supervision sessions either at the beginning or the end of the day so that it does not disrupt the working day too much. It has also been necessary to allow time for supervisees to meet several supervisors from different supervisory disciplines in order to establish who will best suit the individual. Another practical issue has been the paying of supervisors through the NHS payment system (I guess all those managing budgets will have an insight into this one).

I am aware that those of us who receive supervision often have the ethical/moral dilemma of seeing other staff who could do with supervision and for whom it is not provided. This is an ongoing issue within healthcare and other disciplines and our experiences can help in terms of highlighting benefits in our organizations. Perhaps this is a further area where we can model good practice?

Although supervision is not in and of itself training, I believe that its principles can provide evidence for having met elements of the knowledge and skills framework at appraisal and review. This can apply especially within the core areas of communication, personal and people development, service improvement and quality, and also in the areas of assessment and care planning, learning and development, and the exploration of people management.

Overall, I would say that supervision is just part of good governance for healthcare chaplains and that I believe it to be a requirement of our duty of care to patients, relatives and staff.

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Website
www.bacp.co.uk www.psychotherapy.org.uk

Correspondence
Revd Richard Lowndes
Chaplaincy Dept
MP 201, Centre Block, D level
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD
Email: Richard.lowndes@suht.swest.nhs.uk
Tel: 02380 798517

Different Agendas within Psychiatry and Mental Healthcare

Rachel Freeth is an Associate Specialist working in an Assertive Outreach Team in the 2gether Foundation Trust for Gloucestershire. She also has a diploma in counselling (person-centred approach).

Introduction

This article is based on a talk I delivered at the Mental Health Chaplains' Study Conference 'Mind the Gap – from our multiple agendas to our many identities' in October 2008. I was invited to consider some of the different agendas within the psychiatric profession and within our mental healthcare organizations. In doing so I also wanted to engage personally with the topics of agendas and identities, which involved a challenging and valuable process of reflection about who I am both as a person and as a psychiatrist.

Agendas within Psychiatry

This is a hugely challenging time for the psychiatric profession in Britain, which 'faces an identity crisis', according to a recent 'special article' in the *British Journal of Psychiatry* (Craddock et al. 2008). This provocative article entitled 'Wake-up Call for British Psychiatry', by 37 mostly academic psychiatrists, generated very strong responses, via email correspondence with the journal and also in the national press. Essentially, the authors of this article are expressing what they think psychiatrists should be doing – calling for a re-examination of the role and function of the psychiatrist, especially within the multidisciplinary team. Their major assertion is that psychiatry is a medical specialty and should behave like other medical specialties and that service users are disadvantaged by not seeing a psychiatrist who is thoroughly schooled in the medical model. They are concerned that the role of the psychiatrist has been downgraded, referring to a 'creeping devaluation' of medicine within mental healthcare, pointing the finger both at the government and at elements within the profession who have either actively colluded with or passively acquiesced in this state of affairs. They acknowledge the

improvement in psychosocial care and say they welcome it, but at the same time seem to view the development and increasing emphasis on psychosocial care as a threat to the medical role. For them, care that is de-medicalized, i.e. that avoids the term 'illness' and does not offer a thorough, broad-based diagnostic assessment that could lead to precise and specific treatments according to the diagnosis, could be deemed negligent.

What is interesting, and somewhat disturbing, is the polarized debate this article provoked, highlighting a diversity of views that are not readily accommodated within the profession but which, instead, generate tension, conflict and confusion. Psychiatry is a profession ill at ease with itself. Perhaps this has always been the case, but the issue of identity for the psychiatric profession is probably now more pressing than it has ever been as it contends with both its own internally generated agendas and also external pressures and influences such as political agendas and societal expectations. Psychiatry has always been conscious of its difference from other medical specialties. This difference, I think, creates, broadly, two contrasting responses: *the wish to minimize difference*, such as the traditionalist view expressed by the article just mentioned that seeks to affirm psychiatry as a legitimate form of medical practice; and the opposite response, which is to celebrate psychiatry's distinctiveness and *accentuate its difference*. So what of psychiatry's distinctiveness and some of the diversity of views within the profession? It is to this I now turn, and in so doing I would like to focus on the so-called 'medical model' and what I think this term means.

The words 'medical model', an umbrella term, are now quite regularly used when describing a form of care within mental healthcare settings. They are often used sweepingly and without qualification in terms of what precisely is being referred to, other than as something to which other approaches (e.g. the Recovery approach or Person-centred approach) can compare and contrast themselves. I think we need to be a lot clearer about the many aspects of the medical model so as to be clearer about which aspects of it we are critiquing.

First of all, for me, the medical model represents both a *desire to explain* and a particular *way of explaining* problems, often in the language of 'pathology'. Having some form of explanatory theory seems crucial to the medical task, even if that theory is not scientifically proven, as is the case with many psychiatric explanations of mental illness such as biochemical imbalances in the brain. The view that illnesses are biological disease processes currently

dominates British psychiatry, hence the huge role that physical treatments, such as drugs, play in treating mental illness. This aspect of the medical model is one of the main areas in which a diverse range of views are held and which distinguishes psychiatry from other medical specialties. (How many other specialties have to cope with their own subject matter – the nature of disturbance – being so hotly contested, not just from within the profession but especially from outside it?) The terms 'illness' and 'disorder' are regularly challenged – many preferring the term 'mental distress' – highlighting the role language plays in these debates. Many people reject the idea of there being discrete disease entities such as faulty neurotransmitter systems in the brain. For some, like psychiatrist Thomas Szasz (1960), the argument is simple – there is no scientific evidence. Others take the view that there is likely to be some biological correlate to mental distress, acknowledging an association while not positing faulty brain mechanisms as the *cause* of illness. With this view it is possible to be interested in biology, while also being interested in a host of other factors that may influence the development of mental disorder.

These other factors may fit under the broad umbrella term of 'psycho-social factors'. Here we find further diversity of views with different factors given different weight in terms of their explanatory power and influence on mental health, e.g. numerous childhood development and personality theories, the role of interpersonal relationships, family context, power structures within society, poverty, employment, spiritual considerations, etc. What is significant about an emphasis on social factors in particular is that the problem (or pathology) is not seen as primarily residing in the individual but within the environment. There are a number of psychiatrists in this country (particularly those within the Critical Psychiatry Network) who regard an emphasis on biological explanations of mental disorder as misplaced, who do not regard forms of mental distress as primarily medical conditions, who would support psychiatry being demedicalized (i.e. not focusing on organs, tissues and cells) and who attempt to draw attention to the social, economic and, therefore, political determinants of mental distress that are currently largely ignored or minimized.

So why are explanatory theories so important? Here we come to another key aspect of the medical model which I describe as the *method of helping* and which is another area in which there are major ideological differences within the profession. For the authors of the article I previously mentioned, a

psychiatrist's key role is to assess pathology (eliciting symptoms and signs through history-taking and a mental state examination) in order to make a diagnosis, following which is the application of a treatment, e.g. the prescribing of drugs, or a specific psychological therapy, or some other behavioural or therapeutic approach. I think most psychiatrists in the UK view the objective assessment of psychopathology and the deploying of diagnostic expertise as their key task, and certainly it will have been the core element of training. But not all psychiatrists are comfortable with their role being defined so narrowly and some even reject diagnosis and illness language, and attempt to respond to people in distress in a different way, e.g. being interested in what experiences mean to the patient and placing emphasis on subjective dimensions.

While a rejection of the traditional medical method of helping may be based on a rejection of the largely reductionist explanatory theories of mental illness (favouring instead a radically different understanding of the origin of mental distress), for other psychiatrists it may be different issues that lead to uneasiness with the medical model as a method of helping. My own discomfort with the medical model arises from the particular form of relationship and power dynamic it creates, in which the expertise is firmly located in the helper and medical knowledge is given primary importance. Built into the medical model is the psychiatrist's task to define the service user's experience, something I feel uneasy about. Of course, here I am displaying my person-centred credentials, the person-centred approach being one in which the client is considered to be the expert, where it is assumed the client has vast inner resources, and has an innate tendency to grow and heal as long as the right therapeutic conditions can be provided through a particular kind of relationship. While the psychiatrist is in the role of expert, the service user is often a passive recipient (some might even say victim), whose own expertise is bypassed and personal agency ignored. The person-centred approach is also acutely sensitive to power dynamics and all forms of control and oppression, considering much psychiatric practice to be inherently oppressive and controlling. There are other critiques of the medical model, not just from a person-centred perspective, including that it represents what has been called a 'technological paradigm' in which mental healthcare becomes a series of technical tasks, at the expense of relationship and of exploring values and meanings (Bracken and Thomas 2005). The medical model is a very technical method of helping.

I hope I am giving some flavour of the diversity of views, opinions, and hence agendas within the psychiatric profession, especially as they relate to the medical model. One's faith in the medical model will to a large extent relate to one's faith in the values of modern science – objectivity, rationality, reductionism and logical positivism (observable or measurable reality is the only reality that counts). But as critics of the article point out, attempts to uphold the medical model may well have something to do with issues of power and status. The authors are viewed by some as defensively reacting to their perceived erosion of status, influence and loss of role. I think there is something in this.

Indeed, I think it is true that medical authority has been eroded in recent years and the psychiatric profession is rightly called upon to re-examine its roles and values. The increasingly influential Recovery philosophy represents a move away from focusing on pathology, illness and symptoms, affirming values such as hope, choice, personal strength and well-being, the discovery of meaning, acceptance, partnership, etc. In addition, a recent discussion paper by 'The Future Vision Coalition' (2008), which includes organizations such as the Sainsbury Centre for Mental Health, Mind, and Rethink, has attempted to provoke a wide-ranging debate about the direction of mental health policy and urge a radical rethink of principles underlying policy. They identify four areas of policy for which they outline a vision of change. The first area concerns the medical model, pointing out that, historically, NHS mental health policy has been underpinned by medical models and assumptions which have created a division between those who are diagnosed as mentally ill and those who are not. The coalition calls for a shift from the current medical model of mental health to an integrated model where policy takes into account social and economic determinants of mental health. It will be interesting, then, to see how much influence this paper (which also talks about public mental health and Recovery principles) has on future government policy. As for psychiatrists, I think many, on reading such a vision, will feel threatened and question what their role is likely to be in future mental health services. It does represent a dumbing-down of the traditional medical contribution to mental healthcare, and I think this does have a considerable impact on the current and future identity of the psychiatrist. It will be interesting to see how much psychiatrists cling to the medical model or find ways of going beyond it.

Agendas in the Delivery of Mental Health Care

In this next section I move away from considering the psychiatric profession specifically and take a look at some of the many agendas within mental healthcare organizations, particularly the NHS, that impact not just on psychiatrists but on all mental health professionals and mental health chaplains. I aim to give a flavour of the highly complex mix of often contradictory agendas within mental healthcare settings.

For me one of the main agendas that lies behind the huge changes we have seen in our NHS mental health service in the last 10 years is represented by the use of the phrase 'mental healthcare delivery' – the key word being delivery. Care is increasingly purchased, packaged and delivered according to business principles. At times I barely recognize that I am working in a healthcare environment. Clearly there are many political and cultural forces influencing the agendas within healthcare organizations. However, economic factors have played a central role in the drive to restructure services in recent years, with the desire to increase cost-effectiveness and efficiency according to targets and measurable outcomes.

The drive to deliver care along business principles is, of course, aided by the technological paradigm I mentioned earlier. Science lends itself to mechanistic forms of care which we currently see in the proliferation of specific care pathways and protocols for specific problems. Care is increasingly standardized according to diagnostic categories with the overall aim of predicting outcomes that can then be costed.

What about the rise of consumerism and the increasing emphasis on personal choice? Much government policy describes wanting to create services that are *personalized* according to needs (although one might substitute 'wants' for 'needs' as more accurately reflecting the consumerist agenda). And while many would argue that consumerism as an ideology does not belong in healthcare, it does in part emphasize what is often lost in the current system – an appreciation of the individual and their uniqueness.

This is where the Recovery agenda poses such a big challenge to mental health services because I think it highlights huge contradictions at the heart of mental health policy. Intrinsic to the Recovery philosophy is a valuing of the individual, and seeing the need to provide services that can respond in flexible ways around individual needs and preferences according to what is most meaningful for the service user (and carers when they are involved). Yet

this directly comes into conflict with the drive to standardize and streamline care according to predetermined outcomes – the 'one size fits all' mentality.

The Recovery philosophy also talks about notions of 'self-determination' and 'empowerment', moving away from paternalistic practice to valuing the principle of autonomy. Yet how does this sit with another major agenda of mental health services (as understood by government, much of the public and the media), which is to protect society from dangerous people (who may or may not be considered mentally ill)? Mental health services are increasingly preoccupied with managing risk (and the bureaucratic agendas that go with this). The amended Mental Health Act 2007 is influenced by a strong public protection agenda that is likely to trump healthcare concerns when there is clear conflict between the two, as there often is. The social control aspect of psychiatry (of containment and compulsion) is another powerful agenda. Is it too fanciful to imagine that in the future psychiatry will in effect mean forensic psychiatry?

So what about those of us whose agendas are to prioritize relationships and who place the quality of relationship at the heart of mental healthcare? Despite talk of the importance of relationship, it is disappointing to witness so often relationship being understood and talked about in little more than superficial ways. It is clear that there are many different ways in which mental health professionals relate to and enter into relationship with service users. Within psychological therapies there are differing assumptions about the nature and purpose of the therapeutic relationship, with some offering more limited relational possibilities, particularly those that are aligned with the medical model (such as cognitive behavioural therapy). I venture to suggest that the more the medical model operates, the less attention is paid to the quality of relationship and empathic relating. With the dominance of the medical model currently, it is a struggle to speak up for the importance of the therapeutic encounter, of empathically *being alongside* others, being sensitive to meanings and indifferent to outcomes (outcomes as understood by the medical model and managerial agendas).

Finally in this section, I would like to reflect upon one particularly significant (politically driven) agenda which I think impacts significantly on identity. It concerns the preoccupation with structures and functions of services and the development of so-called 'functionalized teams'. In many NHS Trusts, traditional Community Mental Health Teams have been replaced by teams charged with specific and specialist functions, such as Crisis and Home

Treatment Teams, Early Intervention Teams, Assertive Outreach Teams, Recovery Teams, etc. Psychiatrists in many places are now either community psychiatrists or inpatient psychiatrists. This is a significant change to how care is delivered and many – both patients and professionals – have experienced this as detrimental in all sorts of ways. I imagine one of the aims of functional teams is to make it easier for care to be standardized, care pathways and protocols to be created, to make care more efficient and cost-effective. However, I think they have seriously threatened continuity of care and therefore the potential for relationship. Relationship is also threatened by virtue of a focus on the task (i.e. non-relational task) of the mental health professional, which a preoccupation with functions creates. Mental health professionals are valued according to what they do rather than for who they are, especially if what they do can be documented!

Agendas and Identity within Mental Healthcare Settings: A Personal Perspective

In this final section I would like to address more directly the subject of identity, offering a personal perspective in which I highlight some of my own struggles and challenges. But first I would like to share briefly some theoretical ideas about identity that I have found helpful in organizing my thinking.

I want to acknowledge first of all that identity is a rather unclear and multifaceted concept. Furthermore, I notice that different academic disciplines tend to use it with different meanings. It seems to relate to both difference (identity distinguishes from …) as well as sameness. It is something that can result from forces beyond our control, e.g. racial identity according to the colour of one's skin, as well as something we can actively take on, i.e. having some choice over who we identify with (e.g. which political party we vote for). We often refer to identity as something that is fixed, while it is actually more helpful and accurate to think of many aspects of identity as being *in process*. Regarding the latter idea of identity being a process, I like the following description by Hall (1989): '*identity emerges as a kind of unsettled space, or an unresolved question in that space …*'.

However, I have come across two specific and related ways in which identity may be regarded, described by political scientist James Fearon (1999). First, Fearon refers to identity as a *social category* which is distinguished

by implicit or explicit rules of membership (e.g. a particular language or expectations around roles) and which also has sets of characteristics (e.g. certain beliefs, attitudes, desires or moral commitments). One can say that being a psychiatrist or mental health chaplain is a social category. Psychiatrists are distinguished by having had a particular training (in the medical model), and the expectation is that we assess and diagnose mental disorder, as well as abide by the fundamental duties of a doctor (previously enshrined in the Hippocratic Oath). However, I have also highlighted the diversity of thinking and values within the profession such that identifying a uniform set of characteristics within the profession today is very difficult. How about 'mental health professional' as a social category, or 'NHS Trust employee'? Given the diversity of agendas within mental healthcare organizations, it can be a struggle for many to feel the sense of belonging or recognition that such a social category can provide, particularly if one pursues less popular or marginalized agendas, e.g. psychiatrists, such as myself, who critique the medical model and highlight its limitations.

Second, Fearon discusses what he describes as *personal identity*, and I find his ideas around this aspect of identity most interesting. Social identity may well constitute personal identity, but it is essentially, according to Fearon, *a set of attributes, beliefs, desires or principles that a person thinks distinguishes them in socially relevant ways and that* [and this is the interesting bit] *either* (a) *the person takes particular pride in or* (b) *they don't take pride in but which orientates behaviour.* In other words, identity in this sense refers to aspects of ourselves that are in some way very important to us, which may be the basis of our self-esteem and self-respect and which can motivate our actions. If this is true, then I am going to need to express those aspects of myself that I deeply value. Writing my book (Freeth 2007) was very important for me in this respect. I am going to need to express my uniqueness and I will need others to recognize what is important to me and to recognize my uniqueness. We need others to affirm our identity. How would this translate for me as a psychiatrist? Here I feel challenged, given that I find many of my deeply held beliefs and values, such as my appreciation of the person-centred approach, are not readily recognized in environments that seem to operate on different values, e.g. the values of modern science, the values of business and economics.

My biggest challenge is to stay true to myself, whoever that self is. So that means, first of all, that I need to know myself – to identify my beliefs, values and attitudes (something psychiatric training does not readily facilitate). Then

I need to recognize those forces that are influencing me to think and behave in ways that are not true to myself – that are pulling me out of my natural shape. These may be both external and internal forces. An example of external influences in mental healthcare environments for me is the preoccupation with functions and tasks and how this pulls me away from being a thinking, feeling and intuitive person interested in relationship and encounter. Internal pressures (which relate to psychological and emotional needs) might include my need to belong and my need for recognition and acceptance. How much do I follow conventional psychiatric practice in order to be accepted within my social group? Similarly, how much am I afraid to speak out – to speak my truth – because I am afraid of being excluded and rejected?

I think the need to belong is a major influence on identity and its development. It has, therefore, been very important for me to seek out others with whom I can both identify (experience 'sameness' and a sense of belonging to a social group) as well as those with whom I can express my uniqueness (my personal identity). I need to find people who speak my language.

I want to acknowledge another challenge concerning the issue of identity, and one which I am sure chaplains will recognize. The roles of psychiatrist and mental health chaplain are ones people entertain a lot of fantasies about. For me it might be that I can read minds. For chaplains it may be the possession of magical powers. The point I want to make here is that our own sense of identity may be very different to what other people put on us. I find this particularly challenging when I am negatively stereotyped by virtue of my professional identity, or people making assumptions about what I think and how I am likely to behave. I find it hard knowing that a lot of people may initially be very wary of me and I therefore have to work very hard to try to break down barriers to relationship. There is also something here for me about trying to evaluate myself according to who *I* think I am, and not be overly concerned about how others are evaluating me. However, this comes up against the human need to belong and to be accepted, with its inevitable concern about how I am regarded.

Concluding Comments

I'm aware that I've been focusing mainly on the issue of identity for me as a psychiatrist and for us as professionals working in mental healthcare environments, and that I have not addressed the issue of identity where

service users are concerned. I recognize that this is a big topic in its own right, and a crucial one. I think it is important that we consider how the identities of service users are affected by the different approaches to care and the many agendas of mental health settings. I am also aware that if psychiatrists (and other mental health professionals) are confused about their identity, this will also impact on service users, directly or indirectly. I certainly recognize that the more I am uncertain about and preoccupied with my own identity, the less likely I am to be emotionally available to others. It is therefore an important topic to reflect upon in, for example, supervision or personal development groups.

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Correspondence

Rachel Freeth
Email: Rachel.Freeth@glos.nhs.uk

An Unlikely Pairing? An Introduction to the Research Evidence for Spirituality, Religion and Mental Health

Madeleine Parkes is the Researcher for the Spirituality Research programme at Birmingham and Solihull Mental Health NHS Foundation Trust.

Abstract

An emerging interest in the relationship between religion, spirituality and mental health has seen a demand for evidence-based research to be undertaken in this field. This article outlines some of the challenges of providing evidence-based research in an area that appears contradictory to research processes. Also discussed are current research studies that may offer some evidence for the positive effects that spiritual and religious care can have for those recovering from mental illness.

Key Words
Religion; Mental health; Spirituality; Evidence-based research

Main Article

Introduction

A growing interest in the relationship between spirituality, religion and recovery from mental illness has generated a need for evidence-based research to be conducted. Academic interest in the field has been increasing since the publication of John Swinton's seminal book *Spirituality and Mental Health Care: Rediscovering a 'forgotten' dimension* (Swinton 2001). Since then, an ever-expanding dialogue about the role of spirituality and religion in recovery has evolved, ranging from the development of the Royal College of Psychiatrists' *Spirituality Special Interest Group* – the fastest growing SIG with over 2,000 members – to the collection of articles, poems and reflections in

Spirituality, Values and Mental Health: Jewels for the journey (Coyte *et al.* 2007). While interest in the topic is certainly growing in the UK, the evidence base to support or indeed disprove the effectiveness of religious and pastoral care interventions, specific to healthcare services, is very small. This article attempts to give a basic overview of the much larger evidence base for religion and mental health that can be found in the USA, and offers a discussion as to what needs to be done in the UK. This will be explored in the context of the politics and policies of healthcare research.

Problem

An established model of healthcare research dominates the process of conducting any trial or study. A clinical 'randomized control trial' (RCT), in which participants are selected at random, interventions are given 'blindly' and a control group is used to compare results, is considered as one of the most robust and scientific research methodologies one can employ. This is alongside the favoured 'systematic review', which is a thorough search, following strict methods, of collecting and ordering existing studies on a topic. Traditionally, an RCT has been used to test new drugs and other medical interventions in a specific group of people or 'population'. This method usually produces a numeric result – a percentage or figure indicating the success of the intervention, in comparison to the group who did not receive the intervention. Health research typically converses in language such as 'evidence' and 'data', and sets out to prove or disprove objectively a hypothesis, or research question, which has very strict and focused definitions. Naturally, the world of religion and spirituality is not comfortable with 'evidence', 'data' and 'strict definition', preferring instead to talk using language such as 'journey', 'subjective' and 'ineffable'. An unlikely pairing, perhaps?

Research in the USA

Studies available from the USA suggest not. Koenig and colleagues' tome *Handbook of Religion and Health* (2001) collates hundreds of studies conducted into religion and health, both physical and mental. Within this collection there are studies that suggest Jewish people are nearly twice as likely to experience a period of major depression than non-Jews (2001: 119); others

which demonstrate that following a period of 'devotional meditation' reduces anxiety more effectively than simply a relaxation exercise (151), and discussions around studies that argue that if you are part of a religious community you are less likely to become mentally unwell (225). More complex studies are also presented, into the effects of prayer on recovery (126) and the findings that those who are more fundamentally religious are not necessarily more vulnerable to developing mental illness (161).

Within each topic of research, multiple studies are cited and explained, sometimes contradicting the findings of the study reported above it (see, for example, the different opinions on religion having a moderating effect on stress, 2001: 130–1). This apparent contradiction highlights an important point about research: that no method used to conduct the study is perfect, or will necessarily bring about the same results as a similar study. Changing even the slightest part of the study sample – examining a different age group, or people from a different city, or using a different definition or categorization for the condition being studied – could dramatically affect the results.

Therefore the simple question, 'does religion positively affect recovery from mental illness?' cannot be answered with a simple 'yes'. Instead, disclaimers aplenty will follow the 'yes' answer given – 'yes', according to between 65 and 85 per cent of the studies reported in Koenig *et al.*'s book. Other sources would disagree. To respond responsibly to the above question, other questions should be asked: 'What do you mean by religion?', 'Can you define recovery?' and 'What mental illness are you interested in an answer about?' at the very least.

Quite simply, research in any field is a complex world of definitions and design. Add the fact that a person's spirituality is not exactly 'measurable' in any sense that would be theologically acceptable; this further complicates the conducting of research into spirituality and mental health. In the majority of the studies cited in Koenig's volume, the social practices of the person's religion were examined, not the spiritual significance those religious practices had. Instead of asking 'what does going to church actually mean to you spiritually?' the question 'how often do you go to church?' was used as a measure of the depth of someone's spirituality. For those of us working at a theological level, this question lacks any deep insight into the complex and personal nature of a person's belief and faith. Most research methods are not subtle or sensitive enough to address this issue. With all of these issues arising from studies in a nation where religious adherence can arguably be

more concretely categorized, how does the research in the UK negotiate an increasingly multi-ethnic, multi-faith population (DH 2009)?

The UK Scene

In short, there is very little research into the spiritual and religious needs of those experiencing mental illness, although there are some excellent good-practice examples of spiritual care interventions emerging from many mental healthcare providers. A recent literature review concerning Mental Health Chaplaincy explored, in an accessible way, the current status of research into chaplaincy and mental health (Mowat 2008). In particular, it addresses the interest in defining 'spirituality' and the importance of using this term in Britain. It also overviews and advises on the future and potential of chaplaincy services. A fascinating collection of user testimonials has been collected in *The Somerset Spirituality Project* (Mental Health Foundation 2002), and are worth examining to discover the diverse impact chaplaincy and other forms of spiritual care support can have on service users.

From daily contact with service users it is clear to all of us that interventions offered by spiritual care and chaplaincy teams have a transformative effect on patients. Chaplains walk alongside people as they recover, exploring the meaning and purpose of their lives and their journeys, either in the context of a religious faith or perhaps a broader spiritual understanding – sometimes both. This experience is invaluable, but also immeasurable in the ways that clinical research demands. However, there are ways to research these experiences that may subvert the rigid hierarchy of research methodologies, but still ensure the studies are scientifically robust enough to withstand undue criticism.

Local Work

An embryonic research programme into religion, spirituality and mental health has been established at Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). In an attempt to draw the two realms of clinical research and spiritual care closer than they might naturally be placed, small studies have been undertaken to form the beginnings of an evidence base that is relevant to the population of the UK, and specific to the NHS remit of delivering holistic care, of which addressing spiritual and religious needs is

increasingly recognized to be a part. A major research question that has a continually evolving answer is: 'What do we mean by spirituality?' Before any research studies could be designed, the need for a clear and agreed definition arose. However, the team quickly learnt that 'spirituality' would never attract a clear and agreed definition.

Due to the nature of one's spirituality as personal, ineffable, and with the potential to change and grow, a concrete grasp of what was to be measured in the research could not be achieved. Instead, a quest to map the range of understanding people have of the term 'spirituality' began – and continues. Subsequent research projects, therefore, had to have a tighter focus than just 'spirituality'. Some projects addressed the needs of specific faith groups, and again a recognition of the diversity within each faith group guided the focus of the project. One project with a local Sikh community focused on a geographic sample – a particular Gurdwara that attracts predominately Sikhs with a Punjabi heritage. A similar project addressed a specific denomination, organization or 'movement' with the faith group – the Council of Black Led Churches, based in North Birmingham – to great success. In both instances the religious, cultural and organizational issues presented by each community could be addressed in a sensitive and specific way.

When more generic spiritual care interventions were examined and trialled, a broad view of spirituality was used as a definition, encompassing words and phrases gained from the initial collection of 'definitions' used by staff and patients in the Trust. These words included, but were not limited to, 'purpose', 'meaning', 'connection', 'hope', 'journey' and 'peace'. The openness of the definition proved useful when trying to engage service users (and staff) who might not recognize or connect with the term 'religion' or 'spirituality'. Being asked 'What makes you tick?', 'What gives you hope?' and 'Where or from what do you derive a sense of meaning about all this?' opened the door to what might be recognized by the chaplaincy team as a conversation about spirituality, although it may not be labelled as such by the person doing the talking. It was found that for those who *do* have a specific faith, the broader approach to spirituality was still accepted as a way into the conversation, even if this approach does not use terms that are instantly recognizable as 'religious' to some. Naturally, there are some limitations to this approach and this has been recognized in the subsequent development of the definition used in the research projects.

The use of language has become vital in talking to people about spirituality, as some cannot or will not relate to some of the more theological terms that refer exclusively to a specific religious belief or practice. The collaborative working between Spiritual Care and other professions such as Occupational Therapists, Psychologists, Youth Workers and Art Therapists has demonstrated that interventions can be developed that add an additional layer of therapeutic activity to existing efforts (although this is not to say that the spiritual care interventions developed could stand alone).

Rabbi Jonathan Sacks wisely notes that 'If we were completely different we could not communicate. If we were exactly alike we would have nothing to say' (2007: 12). While we may all have our own passionately personal view of spirituality and what it means to us, we also know that the opposite idea could be true for our neighbour. Essential to the research work has been the diversity of the Spiritual Care and Chaplaincy Department at BSMHFT, featuring Christian chaplains representing a wide range of denominations, imams, rabbis, volunteers from the Sikh, Hindu and Buddhist communities, as well as contributions from Humanist colleagues and those with new-age and secular understandings of spirituality. Importantly, the involvement of several service users in developing research ideas, discussing spiritual care interventions and assessments, and producing training materials for staff has been absolutely essential to keep a focus on the reason why the two worlds of research and spirituality are being put together – simply, to help people get better.

Conclusion

As always with new ventures – and clinical research into spiritual and religious interventions in mental health most certainly falls in this category – many questions about methods and intentions have been asked, and much criticism about what is being 'missed out' has been received. As an emerging discipline that aims to bring together two wholly different realms, this is to be expected. The research world demands static, strict and straightforward definitions, which the world of 'spirituality' cannot adhere to. The research world demands quantitative measurements and outcomes, which the world of Chaplaincy in mental healthcare cannot, and should not, be required to provide. However, the gap between these two different worlds can be closed with qualitative studies, and studies that have a specific focus. Ultimately the

purest aim of research is to demonstrate with evidence the best method of providing an intervention. It is certainly a challenging field, but one which we need to be prepared to grapple with.

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Correspondence
Madeleine Parkes
Email: Madeleine.Parkes@bsmhft.nhs.uk

Hope, Prayer, Mental Health

Revd James Hair is Lead Chaplain for Hampshire Partnership NHS Foundation Trust.

Abstract

The experiences of prayer of three patients in a medium secure unit are discussed in the context of the research evidence demonstrating the connection between prayer, religious coping, locus of control and mental well-being.

Key Words
Hope; Prayer; Mental health; Coping; Evidence

Main Article

Introduction

Research by Lindgren and Coursey (1995) found that 83 per cent of psychiatric patients who participated in their study viewed their spiritual beliefs as having a positive effect on their illness.

There is some evidence that coping styles, which involve collaborating with a higher power/God in order to deal with negative life events, can be very positive in terms of people's mental health. For example, one study into church attendees noted that churchgoers hear and learn a moral code based upon sermons drawing upon religious dogma. For those churchgoers using therapy-orientated services, these sermons could then be used as a means of helping them seek a resolution to their problems (Alston 1972). The religiously devout were found to be more hopeful (Sethi and Seligman 1993, 1994). Similar results have been found in other studies in clinical and non-clinical settings as reviewed by Koenig *et al.* (2001).

A sample of 474 UK students were administered questionnaire measures of three aspects of religious orientation, frequency of personal prayer and

church attendance, alongside measures of depressive symptoms, trait anxiety and self-esteem. A multiple regression analysis of the results identified the practice of prayer as the significant factor in the relationship between religiosity and psychological health (Maltby *et al.* 1999).

The Royal College of Psychiatrists defines spiritual practices to include a wide range of activities, ranging from religiously orientated through to secular spiritual activities. These activities may include, but not exclusively:

- belonging to a faith tradition, participating in associated community-based activities

- ritual and symbolic practices and other forms of worship

- pilgrimage and retreats

- meditation and prayer

- reading scripture

- sacred music (listening to, singing and playing) including songs, hymns, psalms and devotional chants

- acts of compassion (including work, especially teamwork)

- deep reflection (contemplation)

- yoga, Tai Chi and similar disciplined practices

- engaging with and enjoying nature

- contemplative reading (of literature, poetry, philosophy, etc.)

- appreciation of the arts and engaging in creative activities, including artistic pursuits

Chaplains in the NHS are encouraged to demonstrate that spiritual and religious care has an evidence base for it to be taken more seriously in the multidisciplinary provision of care (Mowat 2008). This article looks at the experiences of three patients in the context of wider research.

Participants

Three male patients in a secure psychiatric unit attending a Soul and Mind Group discussed 'Hopes and Dreams'. When asked, 'What helps provide you with hope?' the group members, one Christian, one member of the Church of Jesus Christ of Latter-day Saints (Mormon) and one Muslim, maintained that their regular time of prayer nurtured their hope. The type of prayer was distinctive for each of them.

The prayer of the Christian involved recitation of familiar texts, the Lord's Prayer, Psalm 23, a prayer of thanksgiving remembered from childhood, as well as prayers of personal confession and intercessions for the world's people which he had himself composed. Also, reading the Bible regularly was part of his devotion. These devotional activities were regularly maintained three times a day, even when he felt particularly low in mood.

The prayers of the Mormon were more extempore but commenced with thanks to the Heavenly Father and involved requests/petitions and thanksgiving, finishing always 'in the name of Jesus Christ'. Regular reading of the Bible, the Book of Mormon and 'The Pearl of Great Price' were part of his devotion.

The prayers of the Muslim were those set for the regular prayer times and provided by the Qur'an. Also, he regularly read the Qur'an.

Consent

After drafting the paper, the author informed the participants. The following week they were shown the text and made comments, which were included in the final text. They gave consent for the material to be used.

Discussion

All three participants identified prayer as a source of hope. What was not clear from their comments was the connection. It seemed to do with a sense of belonging to and being connected with God, and being able to transcend their immediate limited environment. The prayers seemed not so much about request for an immediate change to circumstances, but rather a recitation of words, or style of prayer, which connected them with God and, for two of them, their religious culture. This would support the comment by

Koenig *et al.* (2001) that 'if one relies and depends on a higher power, one feels less pressure to control circumstances and to worry about the results. This way of appraising stressful life situations cognitively may relieve anxiety and counteract feelings of hopelessness and despair, even in the most desperate of circumstances'.[1] This concurs with some of the evidence linking intrinsic religiosity with locus of control (Rotter 1966; Pargament *et al.* 1988; Watson *et al.* 1995). The report *The Impact of Spirituality on Mental Health* (Cornah 2006) discussed the connection between mental health and spirituality in terms of religious coping:

> Religious coping has been conceptualised as a mediator to account for the relationship between spirituality and mental health, particularly in times of stress. Pollner (1989) suggests that a person's relationship with a divine or imagined 'Other' can have a major impact on their coping abilities.

Limitations of the Study

First, the small number of participants does not permit the conclusion that a connection between prayer and mental health has been proven. Second, the location of the three participants in a secure environment indicates they are not in good mental health; rather, the prayer helps them cope with the situation and ill health in which they find themselves. Third, any major study into the effects of prayer on mental well-being needs to take into account the nature of the prayer and the participant's views of its use.

Conclusion

Further research is necessary into the complex relationship between locus of control and prayer. This short article lends support to the growing body of evidence showing a positive connection between mental health, hope, recovery and spiritual practices. The implication of this growing body of evidence is that those responsible for the provision and management of mental health services need to include patients' religious and spiritual needs as an integral part of the path to recovery. Furthermore, the significance of prayer as an aid to recovery needs to be noted in care planning when spiritual assessment has identified this as important for the patient.

Epilogue: Reflections

Some months after writing this article, and encounters with other patients in the unit and its sister unit, three factors have emerged:

- *The role of the chaplain as 'mentor' for prayer*: 'Will you say some prayers with me?' 'Are these words all right? I'm not very good at it.' 'Will you bring me a prayer book of some kind because I don't know what to say?' Here the emphasis is on the chaplain being a practitioner of prayer with the implications of social learning and modelling (Thelen *et al*. 1979, cited in Argyle 1986).

- *The perception of the chaplain as 'holy man/woman'*: 'Will you pray for me during the week?' 'Will you light a candle for me in your church?' Again, there is an issue here about those being providers of spiritual care not only knowing things but being exponents of the spirituality. (See above.)

- *The implications of prayer being taken seriously by the multidisciplinary team* (Mowat 2008): One patient requested a weekly appointment to continue what had commenced in prison after her conversion. Clearly, for her, regular assistance with prayer was a priority and, with her consent, this was recorded in her notes, so that the significance of this for her well-being would be noted. Conversation with a senior member of the service raised the question of this as a clinical governance issue; the implication was that prayer as a source of hope in the context of recovery should be taken seriously by the team and presumably this is more likely to happen if the chaplain is proactive in it.

In conclusion, what the study and the wider context of it has shown is that prayer is perceived as part of the 'tool box' of the chaplain and in the right circumstances can be used to nurture hope in those for whom it is important.

Note

1 This is expressed in a different way in the New Testament; 'Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God' (Philippians 4:6).

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Correspondence

James Hair
Email: james.hair@ports.nhs.uk

The Theology that Underpins Islamic Chaplaincy

Amar Hegedüs is Chaplain in Lambeth, and Forensic Services Chaplain, South London and Maudsley NHS Foundation Trust.

In the public mind, immediately after the USSR ceased to be perceived as the major threat to the democratic world, that status appeared to have been transferred seamlessly to Islam. This may please the mindless idiots who foam at the mouth and murder innocent people – in the name of Islam – but it horrifies the majority of the world's Muslim populations. While such criminal acts have undoubtedly fanned anti-Islamic sentiments, there is apparently another, far deeper and older resentment.

In a *New York Times* article on 26 October 2009, Ross Douthat posits that Christianity's global encounter with a resurgent Islam could be the reason for Pope Benedict XVI's outreach to Anglicans:

> Catholicism and Anglicanism share two fronts. In Europe, both are weakened players, caught between a secular majority and an expanding Muslim population. In Africa, increasingly the real heart of the Anglican Communion, both are facing an entrenched Islamic presence across a fault line running from Nigeria to Sudan.
>
> Where the European encounter is concerned, Pope Benedict has opted for public confrontation. In a controversial 2006 address in Regensburg, Germany, he explicitly challenged Islam's compatibility with the Western way of reason – and sparked, as if in vindication of his point, a wave of Muslim riots around the world.
>
> By contrast, the Church of England's leadership has opted for conciliation (some would say appeasement), with the Archbishop of Canterbury going so far as to speculate about the inevitability of some kind of sharia law in Britain.
>
> There are an awful lot of Anglicans, in England and Africa alike, who would prefer a leader who takes Benedict's approach to the Islamic challenge. Now they can have one, if they want him.
>
> This could be the real significance of last week's invitation. What's

being interpreted, for now, as an intra-Christian skirmish may eventually be remembered as the first step toward a united Anglican-Catholic front – not against liberalism or atheism, but against Christianity's most enduring and impressive foe.

The Shorter Oxford English Dictionary defines 'foe' as an adversary in feud or mortal combat, a personal enemy, opponent or ill-wisher who is inimical to someone's well-being. It is quite inexplicable to me why Christianity should harbour such strong feelings about Islam – far stronger than the 'righteous indignation and resentment' expressed on discovery of politicians' expenses or lax MOD helicopter and RAF Nimrod safety cultures.

Why would Christians fear Islam's divine message? Is this engendered by fear of competition – cited often as necessary for economic growth and economic well-being – despite there not even being any competition between us? Is it engendered by misinformation and lack of information about Islam – as evidenced when a colleague asked, 'What theology underpins your work?'

If this is so, in the spirit of 'Blessed are the meek . . . Blessed are the merciful . . . Blessed are the peacemakers . . . (Matthew 5:5–9), I felt I should try to allay any fears Christians may have with this precis – a brief introduction to Islamic theology.

Human beings comprise two elements – the body and the soul. Whilst all concern themselves with their bodily needs, most neglect and are indifferent to the needs of that other element – the soul.

While all concentrate on health, nourishment and day-to-day living and wish to present themselves as clean and presentable, the need for a healthy, sound and balanced spirit and soul is vastly more important.

Islam considers that evil thoughts and ill desires darken the spiritual entity and divert attention from the moral values and ethical disciplines that enable basic animal instincts to be restrained. It does not regard pragmatism as a suitable philosophy, or measure, by which to distinguish between reality and fallacy, good and evil, what is right and what is wrong, or if a course of action is to be truly beneficial. With the plethora of conflicts of interest, it is almost inevitable that greed and arrogance will vie with harmony and that considerations of personal interest and advantage will resist cooperation and care.

Islamic theology is based on the following three principles:

1 There is an objective for all of creation. Humanity strives towards perfection, avoidance of negative thinking and adherence to what is honourable and enlightening. To achieve this, Muslims are encouraged to remain vigilant via assessment of a daily record of their actions.

2 Accountability is the foundation of all human behaviour. Everyone is to be accountable for their every utterance and action. Allāh Almighty's omnipresence plays a similar role to that of the CCTV cameras that nowadays record whatever happens on the streets, in shopping precincts, shops, subways and the Underground.

3 Purification of the soul, and continual spiritual exercise to achieve that, is considered to be more important than all the specified rituals of the faith. There is no value in the observance of what is known to be lawful and avoidance of the unlawful – without striving to enhance one's spiritual purity. Even though daily prayer is the major pillar of the Islamic religion, if this does not deter a Muslim from crime and disorderly behaviour, it no longer has validity.

The pre-Islamic era is referred to by Muslims as the age of darkness and ignorance. In those times, society's only value was loyalty to one's tribe. Instead of discourse and dialogue, interactions between tribes and individuals were conducted via retaliation and revenge. Moral values and justice were unknown concepts. People's major motivation was to support their tribal brothers, regardless of their being oppressed or oppressor. Women were looked down upon and new-born girl children were as likely as not to be buried alive. Mercy was not an aspect in the culture of those illiterate peoples. In such circumstances the last and final Divine Message was sent down and the Prophet Muḥammad ﷺ chosen by our Almighty Creator to deliver it.

The most important aspects of the Islamic faith are:

1 To draw people out of darkness into light – Qur'ān 2:257.

2 That this message is a mercy for all of humanity – Qur'ān 21:107.

3 That wisdom, and exhortation to all that is good, is essential for all human interaction – Qur'ān 16:125.

4 That justice, good behaviour, generosity and kindness towards others are benchmarks for life – Qur'ān 16:90.

5 That forgiveness is the yardstick for success and salvation – Qur'ān 2:237, 64:14.

In order successfully to practise the above, Allāh commands all Muslims to obey the teaching of His Prophet ﷺ, and to adopt him as their role model and exemplar – Qur'ān 33:21, He is guide – Qur'ān 13:7, beacon bearer – Qur'ān 33:46, warner and deliverer of glad tidings – Qur'ān 33:45. All Muslims are agreed upon these things.

The doctrine of Divine leadership (of twelve error-free Imams) underpins the Shi'ah faith and guarantees the above-mentioned principles. Having the Imams as further role models and exemplars secures the Path of Perfection and assures that one walks on the right path. The Imams are the loyal and sincere disciples of the Prophet Muḥammad ﷺ in addition to being his progeny and part of his household. Learning Islam from the error-free Imams ﷺ ensures one receives accurate teaching from an immaculate source. It is clear from the sermons of Imam ʿAli ﷺ that they accurately reflect the teaching of his cousin and father-in-law. His words describing the righteous are so moving that one feels oneself to be in his presence.

He describes the righteous (in Nahj al-Balāghah, Sermon 193) as:

1 having clear, plain, non-obfuscating speech

2 wearing moderate dress

3 comporting themselves in a measured and humble manner

4 keeping their eyes closed to that which Allāh has ordained unlawful

5 keeping their ears open only to beneficial information

6 keeping calm and unstressed – both in times of trial and ease

7 aspiring to the level of spiritual purity that, if lifespans had not been ordained, their souls would already have migrated to eternity

8 having their hearts so filled with love of the Almighty that all else is insignificant

9 having the pleasures of Paradise palpable to all their senses

10 having the suffering in Hell palpable to their senses

In order to distinguish between what is true and what is false, the Imam ﷷ said, 'Only four fingers separate what one hears and what one says' – indicating the need to investigate and obtain certainty, rather than simply listen to gossip and rumour. To distinguish between those who are wise and those who are not, the Imam ﷷ said, 'The former think before they speak while the latter speak before they think.' To distinguish between true knowledge and vain assertion the Imam ﷷ said, 'Information that effects humility is true knowledge while that which effects arrogance is not knowledge.'

In a Muslim's journey to perfection, a guide and exemplar is necessary – that is 'the perfect Man' – Insān al-Kāmil – and according to Shi'ah belief, such guidance in the faith is provided by none other than the Holy Prophet of Islam ﷺ and the twelve divinely appointed error-free Imams ﷷ who followed in his footsteps.

In conclusion, may Allāh grant you peace and blessings – Al-salāmu ʿalaykum wa Raḥmatu Allāh wa Barakatuh.

Correspondence

Amar Hegedüs
Email: Amar.Hegedus@slam.nhs.uk

The Core of Islam

The Core of Islam was developed in response to queries from mental health professionals at the South London and Maudsley NHS Foundation Trust. Its aim is to provide a readily accessible resource of information – not limited to one denomination – of this frequently misrepresented subject.

Dedicated to a better understanding between people, it is now accessible on the internet, at: www.coreofislam.com

The Labyrinth: Reclaiming an Ancient Spiritual Tool for a Modern Healthcare Setting

Revd Lizzie Hopthrow is Chaplain at Pilgrims Hospices, Canterbury.

Abstract

A labyrinth is an ancient spiritual tool that is being reclaimed in the modern world as a tool for contemplation. Although our experience is primarily in palliative care, labyrinths are beneficial in any healthcare setting. Pilgrims Hospices in East Kent have used different forms of labyrinths with patients and carers as they have been found to be calming or enlightening. The Department of Health has funded a labyrinth as part of a Therapeutic Labyrinth Garden and this article reports on Pilgrims Hospices' experience as an encouragement for other hospices and hospitals to provide a labyrinth as a part of the spiritual care offered not only to patients and carers but also to staff and volunteers.

Key Words

Labyrinth; Spiritual care; Palliative care; Healthcare; Therapeutic; Calming

Main Article

Defining a Labyrinth

A labyrinth is a single path that winds to a central point and out again – unlike a maze, which has dead-ends and false starts and so can induce anxiety because it is difficult to find your way. A labyrinth, however, frequently induces spiritual or emotional calm and can help in decision-making. It is a timeless mystical and spiritual tool that is poignantly relevant to people approaching death and to their loved ones coping with bereavement. Many people find their burdens are lifted and they are able to begin, at least, to let go of their grief. Although our experience has been mostly within

a hospice environment, we have used the labyrinth in a variety of situations and have discovered that it serves as a potential benefit for anyone with any kind of problem or inner pain.

Figure 1. Maze and labyrinth

An ancient phenomenon that can be found across many cultures and faiths, a labyrinth also appeals to people of no faith at all. Based on the ancient ideas of pattern and spiral, the winding nature of a labyrinth draws us in, not only to the centre of the labyrinth itself but also to the centre of our selves. There we may face our deepest fears, hopes or longings and there is the place of inner healing or enlightenment. For the religious, we encounter the light of Divine love that shines in our darkness and for the non-religious a spiritual experience that may also be of profundity is not unusual.

Currently, there is a worldwide resurgence in labyrinth-building and usage and Jeff Saward in his research has found that the use of labyrinths is re-born every two or three hundred years, usually at a time of some kind of breakdown in society. Working with hospice patients we have discovered deep spiritual needs that are not often met by organized religion but are sometimes met in the mysterious path of the labyrinth. This seems to coincide with a spiritual hunger in society.

Walking a labyrinth may bring mind, body and spirit into balance and, for those who are open to its possibilities, may be the way to a new sense of self, direction or inner peace. It may also be the path to reconciliation with others, or the world we live in or our life situation.

Labyrinths are divine imprints. They are universal patterns most likely created in the realm of the collective unconscious, birthed through the human psyche and passed down through the ages. Labyrinths are mysterious because we do not know the origin of their design, or exactly how they provide space that allows clarity. (Artress 2006a)

Historical Context

Labyrinths date back at least 4,000 years. The classical design has been found on ancient pottery, parchments, clay tablets, coins and rocks. In South America, Egypt, Syria, Spain, Greece, Iceland, Scandinavia, Sardinia, China and India (to name a few places) there is evidence of this mysterious phenomenon appearing across diverse cultures of the world. The history of labyrinths is very long, complex and wide-ranging, and the books and website of Jeff Saward are recommended.

The origin of the design is unknown, but in reclaiming the labyrinth for the modern world we are tapping into a mystery that was birthed in pre-historic times. In Nordic countries there are many labyrinths laid out with stones. These were probably walked by seamen in the Dark Ages before taking to the sea as a blessing on their voyage. Many have been restored in modern times.

In the Middle Ages, however, a significant development took place in the history of labyrinths. During the Crusades, when Christians were unable to go on pilgrimage to Jerusalem, a more complex design was built into the floor of the naves of some of the great European cathedrals, most noticeably in Chartres, France. Christians would there make their pilgrimage, often journeying through the labyrinth in penance, on their knees. The Chartres medieval design is divided into four quadrants with a path of eleven concentric circles to the centre, which takes the form of a rosette. There is much symbolism attached to the design and a full explanation will be found in the writings of Lauren Artress. The six petals at the centre, for example, may symbolize the six days of creation.

Many seventeenth-century English turf labyrinths have been restored and are available to visit today. Nowadays, both classical and Chartres-design labyrinths are being built all over the world as organizations, both sacred and secular, are discovering their potential for inner healing and positive change. A labyrinth is added to the worldwide labyrinth locator every day!

Within Pilgrims Hospices we work with the classical design of labyrinth because it transcends all religious and cultural boundaries but is also inclusive of any religious tradition. It is also less complicated to walk, which suits the context of working with people with decreasing physical ability.

Therapeutic Benefits of Walking a Labyrinth

A labyrinth has been described in many ways, including as a meditative walk, a spiritual journey, a path of prayer, a way of contemplating or a metaphor for our lives. Each person finds their own way round the labyrinth and there is no right or wrong way to walk. When a labyrinth is walked, the analytical left-hand side of the brain gives way to the more intuitive right-hand side and we are led by the path away from stressful thoughts into stillness. The labyrinth leads us into the spiritual part of our being and gives us the potential for inner transformation.

> 'Being pushed in my wheelchair round the labyrinth by my husband, together we found that it was the most spiritual and magical thing we have ever experienced. I have Motor Neurone Disease … and the feeling of inner calm and love made us both feel complete. It was thought-provoking and awe-inspiring, also something together we could share.' (Patient and Carer)

Over a period of more than five years, we have witnessed in Pilgrims Hospices many changes experienced by those who have walked the labyrinth and it has been our privilege to share in some very emotional encounters. Most people have spoken of the calm they have felt; many have been taken into the deepest part of their grief and have spoken of the cathartic nature of that experience. Some have wept and have said that they don't know why. Others have discovered an answer to a problem or received a creative idea. Burdens of guilt have been lifted and the pain of bereavement has been eased. Joy and hope have also been felt and all of these experiences have clearly been real and at the same time mysterious.

> 'It takes me from the horrors of this world to a place where it is peaceful and calm. It's peace in a different way to watching the telly – peace in a way you can't describe or find anywhere else.' (Patient)

A labyrinth walk may be divided into three parts – the walk to the centre, arriving at the centre and the walk out again.

Lauren Artress has helpfully incorporated teaching from the Hebrew Scriptures into a way of walking the labyrinth that relates closely to its three parts. She offers us the Four Rs based on the *Via Positiva* (Blessing),

Via Negativa (Emptying), *Via Creativa* (receiving the creative spirit) and *Via Transformativa* (the transformed person returns to the world to transform it). In Pilgrims we call the three parts Releasing, Receiving and Returning (or Resolving), as Lauren Artress suggests. Usually, because of the end of life context in which we work, and also time constraints, we leave out the first R – Remembering – remembering our blessings before we begin the journey into the labyrinth.

As we walk towards the centre we may become released from stresses and strains, hurts or concerns that cause us tension or emotional or spiritual pain. We let go of anxious thoughts or situations and may enter into prayer At the centre we pause to receive – a blessing, peace of heart, a moment of relief or enlightenment, a deep sense of calm, a creative idea or a resolution. On the way out again we return to the world taking with us our experience of the labyrinth.

> 'The labyrinth is an archetype of transformation. Its transcendent nature knows no boundaries, crossing time and cultures with ease. The labyrinth serves as a bridge from the mundane to the divine. It serves us well.' (Kimberley Saward, Former President of the Labyrinth Society)

Christianity and the Labyrinth

In 2001, some 72 per cent of the population of Britain told the Census that they were Christian (Office for National Statistics) and yet 66 per cent of the population have no contact with organized religion or church (Crabtree 2007). This is borne out in my work as a hospice chaplain as, over several years, countless patients have said. 'I don't go to church but I believe in God', – or, 'I don't go to church but I say my prayers every night'. In the Western world where, in modern times, material values have often taken precedence over spiritual values, spirituality has become a popular concept.

The inclusive nature of the labyrinth welcomes all and there are many ways in which the labyrinth may be used as a tool to help to reconcile humankind's spiritual hunger, especially for those experiencing illness or uncertainty. Reclaiming the labyrinth as a means to meditation, contemplation or prayer is a gift to the modern world and its resurgence provides a path on which the unconditional love of God for every human being may be experienced not only in the head but in the heart, where perhaps the greatest potential for transformation exists.

For Christians, the labyrinth serves as a heart-opener to the tender, healing love of God, shown through Jesus Christ, for all his people on earth. It breaks through the thin veil that separates heaven from earth and brings the beautiful spiritual gifts of peace and joy to those who seek them.

'I entered the labyrinth – fully expecting to be in tears by the time I entered the middle circle. But instead, I felt joy and peace about a situation that I had been thinking about and was on my mind. I feel settled about the things that were troubling me – and feel God's peace.' (Visitor)

Development of Project within Pilgrims Hospices

Making clay finger labyrinths in the Day Hospice inspired patients to request that we make our own indoor fabric labyrinth that they could walk, albeit often with mobility aids. So many reported therapeutic benefits, especially experiences of calm and peace, that it became clear we needed a permanent labyrinth that could be accessed at all times by anyone.

With funding granted by the Department of Health, a Therapeutic Labyrinth Garden was built and is now used by groups of day patients, carers, bereaved loved ones including children, staff, volunteers and, of course, patients and their families from the ward. The labyrinth itself has a path wide enough for wheelchairs. Finger labyrinths are also available for use by patients in their beds. An added benefit is that individuals and groups from the wider community are able to use the labyrinth and this is building valuable links between the hospice and the people in the surrounding area, thus helping to break down barriers around the concepts of death and dying.

Pilgrims have created the first permanent labyrinth in a UK hospice and we are keen to share our knowledge and experience with other healthcare professionals. Labyrinth facilitator training is available through our Education Department and these courses are led by the chaplain and supported by trained volunteers.

Potential for Use of Labyrinths in Healthcare Settings

Other hospices are now exploring the possibilities of having a permanent labyrinth made and it would be worth any healthcare provider submitting proposals to PCTs and Boards of Trustees. Fabric labyrinths are naturally

considerably less expensive and can be made to accommodate the size of a specific space out of a variety of materials and in many different ways. Laying out a fabric labyrinth in a chapel in which religious artefacts have been removed is a way of welcoming people into the mystery of the labyrinth. Any other sizeable space would, of course, work too, but it helps to beautify the space with flowers and candles, for example. The labyrinth is a sacred space and is helped by being 'set aside' as such, if only temporarily.

Providing finger labyrinths for use on wards is another possibility. Wooden ones are expensive and may not pass infection controls but finger labyrinths made from Perspex are now coming on to the market. Drawing labyrinths on to paper or card can be both therapeutic for the creator and also for the one who 'walks' it.

The labyrinth also provides a helpful way for healthcare staff to let go of stress, and chaplains who have responsibility for the spiritual care of staff could find the availability of a labyrinth beneficial. Group walks for staff would be advantageous not only as a means of relaxing, praying or seeking guidance, but also as team-building exercises. I know of a surgeon who regularly walks the labyrinth as a preparation for his day's operating list.

> 'The labyrinth revival reflects the need for a more holistic paradigm …
> Having seen what I have seen and knowing what I know, it is hard for
> me to imagine that any thoughtful and progressive architect or planner
> would conceive of a new church, retreat centre, spa or healthcare
> facility, without including a labyrinth.' (Robert Ferré – labyrinth
> designer and builder, 2003)

Conclusion

When our permanent labyrinth was built, a member of staff said, 'I wonder how that will change the spiritual life of the hospice!' We have yet to realize its full potential, but undoubtedly countless patients and their loved ones have already been helped through a painful part of their life's journey. More staff are walking it or becoming aware of it and the Therapeutic Labyrinth Garden is drawing people into this new sacred space that mysteriously calms and strengthens many of them. The labyrinth is a spiritual tool that is always old and always new.

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Correspondence

Revd Lizzie Hopthrow
Pilgrims Hospice
56 London Road
Canterbury
Kent, CT2 8JA
Email: lizzie_hopthrow@pilgrimshospice.org

Chaplaincy Matters

John Sherbourne is an Honorary Chaplain working with the Leeds Teaching Hospitals NHS Trust.

Abstract

Chaplaincy Matters is a quarterly, twelve-page magazine produced by John Sherbourne. In this article John looks back over the last four years, which have seen his black-and-white, photocopied newsletter grow into a full-colour print and online magazine. The Head of Chaplaincy Services at Leeds, Revd Dr Chris Swift, assesses the impact it has on the service his department provides.

Key Words
Newsletter; magazine; *Chaplaincy Matters*

Main Article

Chaplaincy Matters came about as the result of a conversation I overheard at a volunteer retreat day in 2005: 'I know the chaplains are very busy,' said one lady to another, 'but I do wish there was some way they could find to tell us about all the comings and goings.'

The Leeds Teaching Hospitals NHS Trust is the largest Trust in the UK with Jimmy's – St James's University Hospital – still the biggest teaching hospital in Europe. It currently employs six whole-time chaplains (two Roman Catholic and four Anglican/Free Church), three part-time chaplains and numerous people, lay and ordained, who represent a whole range of faith traditions. In addition, the chaplaincy has the support of more than seventy volunteers. Besides the St James's site, the Trust is made up of four other hospitals: The Leeds General Infirmary (LGI), Chapel Allerton Hospital, Seacroft Hospital and Wharfedale Hospital at Otley.

Shortly after the retreat day and armed with an eight-page dummy – an extremely crude affair made up of clipped, local paper headlines and holiday snaps – I met with chaplain Revd Ben Turner and Head of Chaplaincy

Services Revd Dr Chris Swift and suggested to them that I might put together some sort of newsletter.

So it was that in January 2006 issue 1 of *Chaplaincy Matters* flew off the photocopier. Looking back, I suppose that for all its rough and ready appearance this first edition did everything it was called upon to do: it supplied a long list of names, telephone numbers and email addresses of chaplains, a Q&A interview with two new members of staff, a feature on one of our most experienced volunteers and a diary of departmental events.

Issue 2 followed in April – still in black and white but this time photocopied on lilac paper. My page 1 lead was a picture story about two of our chaplains who had been invited to host prayer and meditation sessions at a cancer support centre. Inside there were pen pictures of six new volunteers, an interview with the Trust's Voluntary Service Manager, the diary, and on the back cover a multi-faith calendar.

It was as I was compiling issue 3 that I got the go-ahead to print in colour. After negotiating with the Trust's Print Unit (the extra costs coming from either the core budget or from Chaplaincy trust funds), I took the decision to increase the print run, which meant that now I could not only give one magazine to each volunteer but, spotting the potential for recruitment, I could ask them to take extra copies to both their ward and to their regular place of worship.

Growing ever more bold, for the next issue I requested an interview with the Trust's Chief Executive. Would he, I asked his PA, speak to me about the role he saw Chaplaincy playing in today's NHS. Sadly, before receiving a reply it was announced that the man I was relying upon to fill pages 1, 4 and 5 was leaving Leeds to take up a post elsewhere. Imagine my surprise, then, when on the very day he left I opened an email from the Chief Exec's office which contained exactly 450 words telling me of 'a new style of Health Service, and the changes we all faced'.

By issue 5 I was feeling that I had settled the magazine down. I was satisfied that its white-on-blue masthead was sufficiently eye-catching and I was happy that I was still managing to find enough 'hard news' to fill page 1. I have to admit that, although it is never quite the case that one 'scoop' fights another, I am, nevertheless, content that such stories as the appointment of the first whole-time, female chaplain at the LGI; details of a catastrophic safety report that forced the immediate closure of St James's landmark chapel and an urgent invitation to volunteers to take a lead role in framing the

Trust's application for Foundation status are – in my book – a good read. Now, as then, page 2 is reserved for housekeeping notices – new appointments, retirements, the diary and details of how inpatients can contact a chaplain. However, by issue 5, I was also very much aware that as readership was now expanding way beyond a particular interest group I needed to seek out what might best be described as Chaplaincy-led human interest stories. This is never easy, but one such report, an account of the part that a Trust chaplain played in arranging for a wedding to take place in an oncology ICU, is still talked about. Meanwhile, the centre pages are always reserved for either a big event like the recent opening of a purpose-built faith centre in the Bexley Wing of St James's £220 million Oncology Centre, or a picture spread like that in issue 13, which carried five images taken at a concert held to celebrate the re-opening of the Jimmy's refurbished chapel.

I have to admit that I often, quite brazenly, use *Chaplaincy Matters* to promote the work of CREDO. Under the direction of Leeds' Head of Chaplaincy Services, Revd Dr Chris Swift, CREDO (Chaplaincy Research, Education and Development Office) is made up of a small group of chaplains and volunteers (myself included) who each year undertake at least one major piece of research into a spirituality/healthcare-related issue. On several occasions I have reported on either the progress or the findings of a particular research project, while in issues 11 and 14, respectively, I used extensive reports from two CREDO conferences which had attracted such high-profile speakers as Dr Harriet Mowat, Managing Director of Mowat Research, Dr Wilf McSherry, Professor of Dignity Care for Older People at Staffordshire University, and personality profiling experts Professor Leslie Francis and Dr Mandy Robbins.

Assessing the benefits that the magazine brings to his department's profile, Chris Swift writes: '*Chaplaincy Matters* has become the central plank in our efforts to communicate what chaplaincy is about to a broad audience. The Chief Executive and Chair get copies, as of course do all our volunteers and local faith leaders but we have little idea about who picks them up on wards, in clinics or in prayer rooms. Without doubt it keeps our service on the radar of people who all too often – and quite understandably – have plenty of other things to think about.

'The impact of its presence is found in unexpected conversations with staff and visitors about the detail of what's going on in chaplaincy. While ward staff might be used to a solitary chaplaincy volunteer calling each week, in the magazine they see a photo of thirty or forty gathered for an event.

Through *Chaplaincy Matters* – especially in a large and anonymous Trust – chaplaincy is seen in the round, with a communal dimension as well as being a source of individual care. The benefit is difficult to quantify, but it gives a visual and moving picture of the issues facing chaplaincy: the personal stories of chaplaincy volunteers, news about new prayer rooms, and information about staff and activities. Throughout its production, quality has been an important issue, as we have wanted the magazine to embody a sense of chaplaincy as a service where excellent communication is essential, especially when we have an audience often unfamiliar with the role of the service. Perhaps the best indicator of the magazine at present is the high uptake of copies left in the chapels and prayer rooms.'

Looking to the future, as editor, my main hope has to be to continue to build on the foundations laid down over the last four years. I'm particularly pleased that, although it isn't yet as professional as we would like, a scanned version of *Chaplaincy Matters* can now be viewed online at the address given below.

But, looking back, I have to say that the thing that pleases me most is that while still fulfilling its initial purpose, i.e. keeping chaplaincy volunteers abreast of changes, *Chaplaincy Matters* is now reaching a far wider readership than I or anyone else ever imagined. As a consequence, it is undeniable that the knowledge that a dedicated, multi-faith chaplaincy service is available to anyone and everyone is finding its way into the lives of many hitherto uninformed people.

Website

www.leedsteachinghospitals.com/sites/chaplaincy_services/*Chaplaincy Matters* (Bulletin)

Correspondence

John Sherbourne
32 Wentworth Avenue
Leeds, LS17 7TN
Email: j.sherbourne@ntlworld.com
Tel: 0113 268 7168, or 07913 505865

Charlie's Miracle:
A Personal View of Hospital Chaplaincy

Ruth Jolly works for the Probation Service.

Of course, Charlie's was rather an everyday sort of miracle. Every medical doctor – and doubtless, every hospital chaplain too – has a story to tell about the patient who unaccountably survived and prospered. And actually, I don't think miracles are all that uncommon. Most of us will one day come across an event where the normal rules of cause and effect just don't seem to have operated and something quite random seems to have occurred. As it did in Charlie's case. And 'miracle' for me is the only word that comes close to conveying the realities of unlikely survival, overwhelming joy and deep, perplexing mystery.

The miracle? On a bitter February day, my student son Charlie crashed in a light aircraft. Witnesses who saw the plane hit the ground expected to find only bodies but against all the odds, on the side that impacted first, Charlie lived. Airlifted to hospital with horrific injuries, he carried on living. The crash, the rescue, the first hours … how he survived these, nobody knows.

In Intensive Care, Charlie, unconscious and disfigured, continued to fight for his life. The consultant said he was strong. We – his parents, sister and brother – willed him on. It's a strange place, ITU. A place of intense drama, played out quietly, with purposeful nurses tending motionless patients monitored by machines that hum and bleep and draw lines.

Doctors, physios and technicians came and went while we sat with Charlie. I recognized the hospital chaplain as he arrived and spoke for a while with the nurses. A few years earlier I'd been a medical social worker in that very hospital. So I knew the chaplain – and thought I understood his role. I wasn't surprised to see him; he'd routinely visit this place where labels like Christian or Muslim or No Faith are irrelevant. He came across to us and we must have spoken, but I remember now only his unhurried concern. There was warmth and reverence in his presence and he brought … not reassurance, and certainly not religion … but calmness and, yes, courage.

After he left I was astonished at how long he'd been with us. Charlie, after all, was holding on, and I knew very well the many demands a hospital community makes of its chaplains. They're assumed to be available to talk with the dying, comfort the bereaved, help with support groups, speak on training days and, of course, take services and administer rituals *in extremis.* Important things, active things, quantifiably busy, useful things – this is what I knew chaplains 'did'. But our chaplain hadn't 'done' anything. He'd given us of *himself* – his steadiness rooted in faith, his time, his solidarity. He'd unflinchingly understood our plight – and that was more honest and more helpful than kindly meant actions or words of consolation could ever have been.

It didn't matter to the chaplain but I'm a liberal Christian; my beliefs are more hypothesis than certainty. And by the time of Charlie's accident, I guess I thought I'd reached all the religious conclusions I was going to. But as Charlie's hold on life strengthened, I pondered. Was I really a Christian at all? And if I was, what did it *mean*? Our chaplain could have told me that trauma frequently throws this kind of challenge at people. As everyday life spins out of control, all our assumptions, values and beliefs are thrown into question and nothing any longer seems safe or self-evident. He'd have listened if I'd wanted to talk, but right then I couldn't dwell on spiritual unease. Charlie was regaining consciousness and suddenly there was frenetic activity.

As soon as he could breathe reliably and communicate a little, a race began to save and rebuild Charlie's crushed right leg. He was moved to another hospital for tissue transplantation and skin grafting. Then back for the fitting of an ungainly frame to facilitate bone growth. The doctors guaranteed nothing, but Charlie readily consented to weeks of relentless surgery, each procedure being followed by recovery and then more surgery. He remained unnervingly, seriously ill and there were times when his – and our – courage wore thin.

Nobody warns you how exhausting helplessness is. The only way through it was a dogged, get-on-with-it concentration on the tasks of daily living. Even so, every setback brought fear: impossible now to keep either pain or gain in perspective. We could have sought out our chaplain and poured out our sorrows – but, stupidly, we didn't feel entitled. We, who'd been given the most precious of gifts: Charlie's life. How could we say we weren't coping? The hospital seemed full of patients whose needs were far and away greater than ours, and we felt ashamed of our anxieties. Isn't it odd? As a social

worker I could have written papers on 'survival guilt' but as a mother, I didn't even recognize we had it.

And then, when the first wave of surgery was complete, Charlie was discharged home. Here, without the distracting routines and dramas of hospital life, the reality of Charlie's dependence and the awful uncertainty of his future were all too evident. And now, for me, there was time – too much time – to contemplate the big issues of faith and belief that I'd shelved since ITU. I didn't know then how common a theme this is in the wake of trauma and how unsettlingly insistent it can become. (Chaplains I've spoken to since have been amazed that I didn't realize so obvious a thing – oh, how readily we suppose our own preoccupations to be unique!) But Charlie continued to be in and out of hospital and, thankfully, the chaplain's door was always open.

I read in the papers now that some are saying our hospitals don't need a chaplaincy service – that the NHS can no longer afford it and that religious organizations themselves should meet the costs. They've missed the point. Maybe they're unaware that today, most chaplaincy involvement is not with 'religious' people at all. Trust – faith if you like – in the essential goodness of existence, and hope that love and care will, one way or another, triumph, is the desperate desire of many who find themselves in the alien environment of a hospital, in frightening circumstances. Few of us can count on our own resources to see us through and many people who describe themselves as of 'no faith' will turn in gratitude to a chaplain who, without any kind of preaching, will speak to that which is vulnerably human, and humanly spiritual in any of us. Multi-faith, no faith – doesn't matter.

Furthermore, the chaplain is counter-cultural, and that's good for any organization. Though part of the hospital, he or she isn't in thrall to its relentless battle against time and the processes of disease and death. Though understanding well the language, the meaning and the risks of medical interventions, he or she never sees a 'gut', a 'leg' or a 'blood disorder', but always and only a person. And the chaplain has no established place in the hierarchy. He or she can talk with consultants and cleaners, technicians and therapists – even social workers – with knowledge and appreciation. That's the job spec: to be kept and developed, or binned to save cash. I know where I stand.

So Charlie came home and life thereafter was a breeze? I wish! Charlie was fiercely brave but, for a long time following his discharge, he was vulnerable. We, his family, were by turns respectfully supportive, and then

unhelpfully interfering. His friends kept in touch but during the long months when Charlie was stuck at home in a wheelchair, waiting for bone to grow and scars to heal, they had lives to lead. It all took a long time. Charlie's successful battle to recover his habitual optimism, his physical independence, his social life and a career, consumed a whole portion of his young life. And those of us, family and friends, who, in our different ways supported him, made eventful journeys of our own.

Some years down the line, as a project for Lent I wrote about all this – about what happens in the aftermath of a miracle. It's a book about survival and the real struggle to return to 'normal life' without losing the joy and the wonder of all the extraordinary experiences along the way. It isn't a book about hospital chaplaincy but when I needed 'back cover blurb', the first person I thought of was our chaplain – a chaplain who, as part of his everyday care for patients and their families, had accompanied us on a journey that was both eminently practical and profoundly spiritual, from ITU into a hopeful future.

Something Absolute is published by O Books at £11.99.

Correspondence

Ruth Jolly
Email: ruthiejolly11@yahoo.com

Book Reviews

Emerging Values in Health Care: The Challenge for Professionals

Edited by STEPHEN PATTISON, BEN HANNIGAN, ROISIN PILL and HUW THOMAS

Jessica Kingsley Publishers, London, 2010

Paperback, 256 pages. ISBN 978-1843109471. £39.99

This book bills itself as 'the fruit of a four-year conversation about professional values in health care'. It has an interesting format, in that each chapter is written from an academic viewpoint and followed by a 'Response', from someone closer to 'the coalface'. In some cases the writer of the response agrees with the original writer of the chapter and develops key themes, and in others challenges some of the material in the chapter. Thus the reader is more actively drawn into the debates about values.

The book begins with two very informative chapters that set the scene in which the NHS has developed, and that offer a clear perspective of what lies behind our debates about values. These are followed by individual chapters covering the values of various areas of healthcare: medical professional identity formation; general practitioners; mental health nursing; adult general nursing; pharmacy; genetic counselling; chaplaincy; and management. The final chapter attempts to draw together the various themes of the book and at least glance in the direction of the uncertain future that awaits the NHS.

The chapter on 'The Chaplain's Dilemma' is written by Paul Ballard, and claims to cover 'the place of the chaplaincy service within the NHS and its particular contribution and the pressure to conform to the professional models found in health care' and 'the changes demanded by working in a multi-faith community and the implications of the emergence of "spiritual health" as part of the healing process', a challenge indeed in 15 pages! The material covered in the first few pages would be very familiar to most chaplains, which left me thinking that this chapter is really intended

as an introduction to a couple of specific aspects of chaplaincy for those professionals engaging with chaplains, but not working in chaplaincy: outward- rather than inward-facing.

The book makes for very interesting reading; however, it is difficult to determine the primary audience. The general information is its greatest asset: the 'specialist' chapters seem to be set at a level that would inform people from outside the specialism, but probably add little that is new to any debate on values from within the specialty. A generous estimate would be that only about a quarter of the pages are of direct relevance to chaplaincy. Given the high cost of the book (£40 seems a little steep for a 250-page soft-back book, even one from such a reputable publisher), this makes it quite an investment for personal purchase. But I would think it would be a book that even in these stringent times should be found in any self-respecting Trust library, particularly one that takes training in multidisciplinary working or CPD seriously.

Revd Annabel R Barber
Senior Chaplain, Diana Princess of Wales Hospital, Grimsby

Hospital Chaplaincy in the Twenty-first Century
By **CHRISTOPHER SWIFT**
Ashgate Publishing, Farnham, Surrey, 2009
Hardback, 212 pages. ISBN 978-0754664161. £45.00

Chris Swift's book is a welcome addition to current chaplaincy writing. It is an overview and analysis from someone who has been immersed in active chaplaincy but who has also been able to stand back and reflect historically on the changing face of the chaplain in hospital and healthcare settings.

The first section of the book looks at the early history of hospitals and chaplains into the middle of the twentieth century, with the NHS and the more recent history under healthcare reform under 'New Labour'. The early history placed faith and spirituality at the heart of the hospital with the chaplain a powerful presence to reinforce moral behaviour. More recent history looks at the ambiguities of the chaplain's role. Swift explores the process that took place with the loss of a given power within the organiza-

tion. In particular, in the 1960s and 1970s, how in an all-male chaplaincy the 'significance of the chaplain is seen to rest in his personal qualities and how he relates to both patients and staff in the hospital'. During the first 50 years of the NHS, as the religious basis of British society changed, more and more hospitals appointed full-time chaplains and the process of rethinking the role has been essential.

Following this historical review, sections of the book then address two very relevant and current issues affecting chaplaincy. The first, entitled 'The Battle of Worcester', explores the decision taken by that Trust to decimate their chaplaincy establishment and the high-level campaign that followed with the reinstatement of funding for the department. The second, exploring ethnography, not the easiest part of the book to embrace, then roots the subject in a very useful 'auto-ethnography'. The description and discussion of the baptism of a dying/dead baby I found particularly pertinent to the sharp end of difficult pastoral decisions which regularly face working chaplains.

Later parts of the book explore the interrelationship between spirituality and secularism in our current climate and ask the question: 'Who Are Health Care Chaplains?' At present, all chaplains have a dual responsibility, to NHS management and faith community leadership. This sometimes thorny issue is explored with regard both to the historical and ongoing role of the Hospital Chaplaincy Council and its relationship to Chaplaincy professional bodies, and to how this has also influenced the development of the Multi Faith Group for Health Care Chaplaincy. This Group has always been closely linked to the Hospital Chaplaincy Council by the serving officers.

Swift here reflects on the relationship between chaplaincy bodies, seeing it as having been very much part of a process. Perhaps more time is required to enable a clearer picture of the vital issues thrown up in the last 20 years as chaplaincy has battled to find an identity for the twenty-first century.

A recurring theme is that chaplaincy very often 'attracts' those whom the Faith Community leadership find difficult to place: those in same sex relation-ships and clergy couples when both are ordained. This is seen by the leadership as both a 'solution', and as offering a strength to chaplaincy, as it is often working at the edge of orthodoxy within the particular faith doctrine and practice.

I thoroughly enjoyed the book and found it stimulating. I would recommend it to all serving healthcare chaplains, and chaplains from other sectors may well find it very relevant. It would be useful for line managers of

chaplaincy team leaders, although some sections would be more accessible than others. I would add to these readers those responsible for pastoral education in theological colleges and those responsible for the deployment of clergy.

As with many current books, the price may deter some readers but a copy held in each chaplaincy department would be a wise purchase.

Revd John Wood
Chaplain, Sherwood Forest Hospitals NHS Foundation Trust

Pastoral Supervision: A Handbook
By **JANE LEACH and MICHAEL PATERSON**
SCM Press, London, 2010
Paperback, 192 pages. ISBN 978-0334043256. £18.99

It took some 30 years through the middle of the twentieth century for the practice of supervision to become the norm in the psychotherapy and counselling professions. It is, therefore, unsurprising that after a similar period of promotion and advocacy, supervision has not yet become the norm in pastoral ministry. There has been significant progress, however, starting with Frank Lake in the earliest days of 'clinical theology', through such books as John Foskett and David Lyall's *Helping the Helpers*, published over 20 years ago, and Michael Carroll's several books published in the 1990s.

Indeed, David Lyall writes the foreword in this new volume: 'This is a book that was waiting to be written', he says, and he also points out that it is both practical and theological. It sets out to describe the process of supervision, but also to indicate its theological basis.

The book is subtitled *A Handbook*, and its format is essentially that of a book to be used by those engaging in pastoral ministry 'at the coalface'. Much more than 'hints and tips', it lays out the underlying themes that permeate all our work, especially the 'giving of attention to the other', and to the context and the 'story'. It looks at the various forms of supervision, including peer group supervision, as well as individual one-to-one practice.

Perhaps the word 'supervision' is itself a barrier to people taking the notion seriously. It has hierarchical connotations, and for some, the idea of supervision suggests the infantilization of the supervised, and the superiority of the supervisor. That is far removed from the practice advocated in this book. The dialogue and the relationships described are those of people giving attention to each other, both offering and listening for the sake of those among whom they minister. It is full of much wisdom, based on considerable experience and much reflection. I warmly commend it to all engaged in ministry, especially in hospital chaplaincy.

Revd Denis Gardiner
Supernumerary Methodist Minister, former hospital chaplain and pastoral supervisor

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Children and Spirituality: Searching for Meaning and Connectedness

By **BRENDAN HYDE**

Jessica Kingsley Publishers, London, 2008
Paperback, 192 pages. ISBN 978-1843105893. £17.99

There are many techniques for imparting knowledge to children. Educational theories and models abound and children are offered abundant opportunities to learn in different ways, adapted to their own needs and abilities. The cognitive development of our children is well studied and well managed, but what of their spiritual development? In this book Brendan Hyde has built in particular upon the earlier research of David Hay and Rebecca Nye (*The Spirit of the Child*, rev. edn., 2006, London: Jessica Kingsley) into the spirituality of children. Hyde looks at how we can recognize children's spirituality and has tried to show us ways in which we can nurture that spirituality.

This is a timely book in a culture which has come to value the educational attainment of our children above all else, and which is in danger of making our schools into places which value only academic achievement. Brendan Hyde's book reminds us that there is more to education than exam results,

and that as a society we need to remember to allow our children to be children, to look at ways in which we can enhance their childhood and, both as parents and as schools and indeed whatever our reasons for coming into contact with children, to remember the importance of spirituality if we are to encourage the growth of the whole person.

Hyde describes rather than defines spirituality. He does this from three perspectives: its relationship to institutional Christianity, as a natural human predisposition, and as the Divine at the core of the Self and of all existence, connecting Self with Other. Vital to spirituality for Hyde are the notions of connectedness and relationality, but he sees it as more than this. It is an essential human trait, concerning the movement towards Ultimate Unity, or becoming one with Other. Spirituality is an outward expression of this for Hyde.

Hyde, who is based in Australia, set his research firmly in the context of previous studies and uses the theoretical perspective of hermeneutic phenomenology. He used the categories, developed by Hay and Nye, of awareness sensing, mystery sensing and value sensing for his three meetings with each of six groups of children drawn from three different primary schools. From this research he identifies four characteristics of children's spirituality. These are: the felt sense, integrating awareness, weaving the threads of meaning and spiritual questing. Although it was not part of the focus of his research, he also discovered two factors which he believes inhibit spirituality in children. These are material pursuit and trivializing.

Had the book ended here it would have been an interesting and valuable theoretical text, but Hyde moves beyond these research conclusions to offer us some suggestions as to how the spiritual lives of children can be nurtured. These include the creation of appropriate space, which needs at times to be space without the presence of an adult; the making of time, to engage in the present moment and to be used, rather than material excess, to give value to our children; the use of sensorial and tactile activities to give expression through the child's body; and the nurture of relationships. He also argues that the classroom should be a place of three-dimensional learning where not only the cognitive and affective but also the spiritual dimension has a vital place. If anything, I would have liked the author to dwell a little longer upon the practical things we might do to encourage the development of our children's spirituality. But that is maybe the subject for another book.

This is an important work for all of us concerned in any way with the

nurture of children. Ultimately, it is hard to see how spiritual growth could be planned as are other aspects of children's education and development. However, as Hyde underlines, we need to find ways of giving opportunity for that growth, of making room and giving opportunity for spiritual development, and of responding to the spirituality of children for whom we care.

Revd Fran Kissack
Chaplain, Hull and East Yorkshire Hospitals NHS Trust

And Only the Seagulls Are Laughing
By **NORMAN SETCHELL**
Milton Contact Ltd, 2010
Paperback, 26 pages. ISBN 978-0956264947. £6.00

This book of prose and poetry is a valuable asset, although it is a specialized subject area and would be best appreciated by chaplains and ministers. 'An Ash Wednesday' is a good descriptive piece of prose, and especially clever is the analogy of fishermen returning their catch likened to the committal part of the burial service.

In the poem 'Then out of the ground ran children laughing', there is a good description of a visionary moment. This is good in the hands of chaplains and ministers but I wonder how a bereaved mother would view the idea? It is possible that a chaplain may have lost a baby or child and this may help, but on the other hand it may not.

On page 18 there is a wonderful version of a hymn that could be sung to the tune 'Finlandia'. This was a thoughtful composition which I sense could help those persevering through either personal suffering or the sufferings of loved ones. I would use these words personally in the context of some of the services I conduct.

Overall, this book contains high-quality poetry which resonates with the thoughts and prayers of chaplains everywhere, although its appeal would be largely to the limited audience of chaplains and ministers. Personally, I enjoyed its contents, its sensitivity to spiritual truths and its integrity. This

was evident in the poem entitled 'Taking the anger', which resonates with the day-to-day experiences of chaplains. This book was honest, straight-forward and in touch with the hospital chaplain's daily experiences. It will be a valuable aid to both new and experienced chaplains.

Revd Brenda Abbott
Chaplain, Sherwood Forest Hospitals NHS Foundation Trust

Notices

NHS Hospital 'Chaplaincies' in a Multi-faith Society: The Spatial Dimension of Religion and Spirituality in Hospital

Authors: Dr Peter Collins, Professor Simon Coleman, Dr Jane Macnaughton and Dr Tessa Pollard.

Department of Anthropology and Centre for Arts in Humanities Health and Medicine, Durham University.

The Aim of the Study

The main aim of this study is to describe the existing chaplaincy facilities across five NHS acute hospital Trusts in the north-east of England and to present and analyse the perceptions of users (chaplains, chaplaincy volunteers, hospital staff, visitors and patients) of these facilities, and also to identify and understand the various uses to which these facilities are put.

Our focus is on the ways in which chaplaincy facilities are used and what these facilities *mean* to those who use them. For this reason the report includes many direct quotations from people who use or have used chaplaincy facilities.

Report Structure

This is a report about the spatial characteristics of hospital chaplaincies located across five NHS Trusts in the north-east of England and is organized as follows. Following a brief introductory section (*Preamble*) and this overview of the way the report is organized (*Report Structure*), we present the *Executive Summary*, a concise summary of the Report, identifying in particular the key findings. We present our aims and objectives along with the questions we have sought to answer in this report in *The Research Question*. There follows an

account of *The Context* of this research project, in which we consider the cultural (including the organizational) and more specifically, drawing on some of the key texts dealing with hospital chaplaincy in the UK during the past 25 years. In terms of data collection this is a relatively complex project, and in the next section, *The Study Design*, we describe various methods used by the project team. The most important section, *The Findings*, draws on the vast amount of data accumulated during the project. Given the quantity of data, we thought carefully how best to present the most significant findings. We have adopted a broadly thematic approach, drawing where appropriate on both quantitative (numerical) and qualitative (non-numerical) data. Included in this chapter is a brief report on a distinct data set – prayer requests, collected over a ten-year period from the chapel in the JCUH. We also present findings from our Mood Survey, which represents a novel means of assessing the levels of stress experienced by those using a hospital chapel. We review the most significant findings and list our recommendations in the *Conclusion*. A list of sources cited in the report is provided in the *References* section. Documents generated during the study which will be of interest to some readers are included in the *Annexes*.

The Report can be accessed at: http://dro.dur.ac.uk/5279

NB: It is a large document (210 pages, including 37 colour photographs).

Dr Peter Collins
Email: p.j.collins@durham.ac.uk
Tel: 0191 334 1612

Performing Rights Society

As I planned music therapy sessions – 'healing' and 'spiritual' music to contribute to the well-being and support of people from a variety of world cultures and spiritual backgrounds – the issue of performing rights licences and penalties for avoidance were being raised in the public domain. This is a subject not previously considered by our chaplaincy team, but one that appeared to need clarification. To share the outcome of our findings, I reproduce below the email response received from the Performing Rights Society.

From: *dewayne.ector@prs.co.uk*
Subject: *PRS Music Licence for Hospitals*
Date: *4 August 2008 12:53:25 BDT*
To: *hegedus@...*

To whom this may concern:

As promised in our earlier phone conversation this morning, I can confirm that PRS does not seek to license any treatment areas, wards, operating theatres or therapy rooms within hospitals. Public waiting areas, restaurant/café/canteen areas, offices and staff social club/bar areas are still subject to PRS licensing.

Regards,
Dewayne Ector – Music Sales Advisor – Customer Acquisitions
www.prs.co.uk

It seems incontrovertible that areas designated for religious/spiritual treatment and/or therapy are covered by the above – regardless of being referred to as Chapel, Room of Peace, Prayer Room or other title.

Amar Hegedüs
Email: Amar.Hegedus@slam.nhs.uk

Endpiece

To Him they brought the sick, the lame, the blind,
    they queued for hours to be a lucky one,
to seek His touch and find His gaze so kind
    and from the bonds that bound them be undone.

What questions did He have for God above –
    the world in all its sorrow was laid bare –
how could He still speak of his Father's love
    as He was torn in agony of care?

Did He find answers when He went to pray,
    or just the strength to open up again,
responding to the gift of each new day,
    sharing in laughter love and joy and pain?

Good God, who looks with grief upon the world,
from pain and darkness may new life unfold.

Mark Newitt
Chaplain, Sheffield Teaching Hospitals

Instructions for the Submission of Articles

If you wish to discuss an article before submission to the *Journal of Health Care Chaplaincy*, please contact the editor by email (at: meg.burton@gmail.com) or on 07976 597971. 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/experimental articles. Our main articles can be as substantial as 3–4 thousand 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 the editor. 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. For example:

  The Spiritual Nature of Nursing P.V.S. Patients
  Revd Jim Dobson is the Chaplain, University of Dovedale, Hodness Hospital, Worcester, UK.

- Contact details should be provided for correspondence, including an email address. These 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 website. Please indicate clearly at submission if you would not wish your article to be published in this form.

- Main articles should be headed by a short abstract. 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 (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 and the page number (if relevant).

  e.g. Smith (1997: xxx) 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, then the year in brackets.

  e.g. Mitchell and 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 authors' names in the reference section, up to three authors, followed by *et al.* if there are four or more authors.

- If you use referenced material to support your comments, the references should 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 and 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 number (if not the first)

- the place of publication

- the publisher's name

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

If you are referencing a contribution to a book, provide:

- the name of the contributor

- the title of the section or the chapter (do not use quote marks)

- the relevant page numbers

> e.g. Wilson RE (1996). Transcutaneous electrical nerve stimulation. In: M Leflowitz, AH Lebovits, with DJ Wlody and SA Rubin (eds.). *A Practical Approach to Pain Management.* Boston: Little, Brown, pp. 136–41.

If you are referencing an article, provide:

- the name of the author(s) followed by initial(s)

- date of publication (in brackets)

- the title of the article (do not use quote marks)

- the name of the journal (in *italics*)

- volume number (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, UWCM.

Submission Dates

Articles submitted for consideration should be sent to the editor by 30 January for inclusion in the spring/summer issue and by 30 August for the autumn/winter issue. Late submissions are welcome at the Editor's discretion.

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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Kings Mill Hospital
Mansfield Road
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Nottinghamshire, NG17 4JL
Email: John.Wood@sfh-tr.nhs.uk
Tel: 01623 672467, or 07732 791390

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Revd Meg Burton
Bassetlaw District General Hospital
Worksop
Nottinghamshire, S81 0BD
Email: meg.burton@gmail.com
Tel: 01909 502846, or 07976 597971

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Revd William Sharpe (JHCC Subscription)
CHCC/Unite
Unite Health Sector
128 Theobald's Road
London WC1X 8NT
Email: William.Sharpe@unitetheunion.com
Tel: 020 3371 2004

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National Officers of the CHCC

President

Revd Mark Stobert

Email: mark.stobert@dgoh.nhs.uk

Tel: 01384 456111, ext 2352/2244

Vice-President

Revd Gareth Rowlands

Email: gareth.rowlands@papworth.nhs.uk

Tel: 01480 364121

Registrar

Revd William Sharpe

Email: william.sharpe@unitetheunion.org

Tel: 020 3371 2004

Professional Officer, Unite Health Sector

Carol English

Email: carol.english@unitetheunion.org

Tel: 020 3371 2013

Treasurer

Revd Nick Flood

Email: nick.flood@waitrose.com

For details of the regional representatives and other appointments,
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Correspondence Address

(for the Registrar and the Professional Officer, Unite Health Sector)

CHCC/Unite
Unite Health Sector
128 Theobald's Road
London
WC1X 8NT

Websites

CHCC
www.healthcarechaplains.org

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